2022 PROVIDER ORIENTATION

Welcome to Wellcare by Allwell

Formerly Allwell from Arkansas Health & Wellness

AGENDA

- Plan Overview
- Membership, Benefits, and Additional Services
- Providers and Authorizations
- Preventive Care and Screenings
- Medicare STAR Ratings
- Web-Based Tools
- Network Partners
- Billing Overview
- Meaningful Use: Electronic Medical Records
- Advance Directives
- Regulatory Information
- Fraud, Waste, and Abuse
- CMS Mandatory Trainings
- Q&A

PLAN OVERVIEW

WHO WE ARE

- Wellcare by Allwell is a Medicare Advantage plan.
- We provide quality healthcare you'd expect from a big company, delivered at a local level.
- That means our members benefit from strategic care coordination and programs through strong and collaborative relationships we build with healthcare providers and community organizations.

- Wellcare by Allwell is designed to give members:
  - Affordable healthcare coverage.
  - Benefits they need to take good care of themselves.
  - Access to doctors, nurses, and specialists who work together to help them feel their best.
  - Coverage for prescription drugs.
  - Extra benefits that aren't covered by Medicare Part A or Part B (Original Medicare).

CONTINUITY OF CARE TO MEDICARE MEMBERS

Wellcare by Allwell provides complete continuity of care to Medicare members.

This includes:

- Integrated coordination of care.
- Care management.
- Co-location of behavioral health expertise.
- Integration of pharmaceutical services with the Pharmacy Benefits Manger (PBM).
- Additional services specific to the beneficiary needs.

Our approach to care management facilitates the integration of community resources, health education, and disease management.

Wellcare by Allwell promotes members' access to care through a multidisciplinary team — including registered nurses, social workers, pharmacy technicians, and behavioral health case managers — that is co-located in a single, locally based unit.

wellcare By allwell™

MEMBERSHIP, BENEFITS, AND ADDITIONAL SERVICES

MEMBERSHIP

- Medicare beneficiaries have the option to stay in the original fee-for-service Medicare plan or choose a Medicare Advantage plan from Wellcare by Allwell.

- Advantage members may change primary care physicians (PCPs) at any time. Changes take effect on the first day of the month.

- Providers should verify eligibility before every visit by using one of the below options:
  - Website: Wellcare.ARHealthWellness.com
  - 24/7 Interactive Voice Response Line: 1-855-565-9518
  - Provider Services: 1-855-565-9518 (TTY: 711)

MEMBERSHIP ID CARDS

PLAN COVERAGE

Our Medicare Advantage plan covers:

- All Part A and Part B benefits by Medicare.
- Part B drugs, such as chemotherapy drugs.
- Part D drugs, no deductible at network retail pharmacies or mail order.
- Additional benefits and services such as:
  - Dental
  - Vision
  - $0 PCP copay
  - $0 generic prescription drugs
  - And more!

PHARMACY FORMULARY

- The pharmacy formulary is available at Wellcare.ARHealthWellness.com.
- Please refer to the formulary for specific types of exceptions.
- When requesting a formulary exception, a Request for Medicare Prescription Drug Coverage Determination form must be submitted.
- The form is located at Wellcare.ARHealthWellness.com beneath the Pharmacy Benefits menu. Under Pharmacy Policies & Forms, select Coverage Determinations and Redeterminations.
- The completed form can be faxed to Envolve Pharmacy Solutions at 1-800-977-8226.

COVERED SERVICES

- Hospital Inpatient
- Hospital Outpatient
- Physician Services
- Prescribed Medicines
- Lab and X-Ray
- Transportation
- Home Health Services
- Screening Services
- Dental
- Vision Services
- Hearing Services
- Behavioral Health
- Medical Equipment and Supplies
- Appropriate Cancer Screening Exams
- Appropriate Clinical Screening Exams
- Initial Preventive Physical Exam — Welcome to Medicare
- Annual Wellness Visit
- Therapy Services
- Chiropractic Services
- Podiatry Services

ADDITIONAL BENEFITS

Hearing Services

- $0 copay for one routine hearing test every year.
- $0 copay for one hearing aid fitting evaluation.
- $0–$1,580 coverage limit per year for hearing aids (dollar coverage dependent upon service area; 2 hearing aids total—1 per ear, per calendar year).

Dental Services

- Two oral exams per year with no copay.
- Two cleanings per year with no copay.
- One dental X-ray per year with no copay.
- $750–$1,500 in comprehensive dental benefits per year (dollar coverage dependent upon service area).

ADDITIONAL BENEFITS

Vision Services

- One routine eye exam every year.
- One pair of glasses or contact lenses every year.
- $200–$300 limit (dollar coverage dependent upon service area) for eyewear each year.

Over-the-Counter Items

- Commonly used over-the-counter items available at HealthyBenefitsPlus.com/WellcareByAllwell.
- Conveniently shipped to member’s home within 5–12 business days.
- Call Member Services at 1-855-565-9518 (TTY: 711) to order items. Up to $50 allowance per calendar quarter.

ADDITIONAL BENEFITS

- 24/7 Nurse Advice Line
  - Free health information line staffed with registered nurses 24/7/365 to answer health questions.

- Certified Fitness Program
  - At specified gyms at no extra cost.

ADDITIONAL SERVICES

Multi-Language Interpreter Services

- Interpreter services are available at no cost to Wellcare by Allwell members and providers without unreasonable delay at all medical points of contact.
- To get an interpreter, call us at 1-855-565-9518 (TTY: 711).

Non-Emergency Transportation

- Covered for a specified number (dependent upon the member's service area) of one-way trips per year, to approved locations.
- Schedule trips 48 hours in advance using the plan's contracted providers.
- Contact us at 1-855-565-9518 (TTY: 711) to schedule.

PROVIDERS AND AUTHORIZATIONS

PRIMARY CARE PHYSICIANS

- PCPs serve as the member's "medical home" and provide the following:
  - Sufficient facilities and personnel.
  - Covered services as needed.
    - 24 hours a day, 365 days a year.
  - Coordination of medical services and specialist referrals.
  - Members with after-hours accessibility using one of the following methods:
    - Answering service.
    - Call center system connecting to a live person.
    - Recording directing members to a covering practitioner.
    - Live individual who will contact a PCP.

UTILIZATION MANAGEMENT

- Authorization must be obtained prior to the delivery of certain elective and scheduled services. The preferred method for submitting authorization requests is through the Secure Provider Portal at Provider.ARHealthWellness.com.

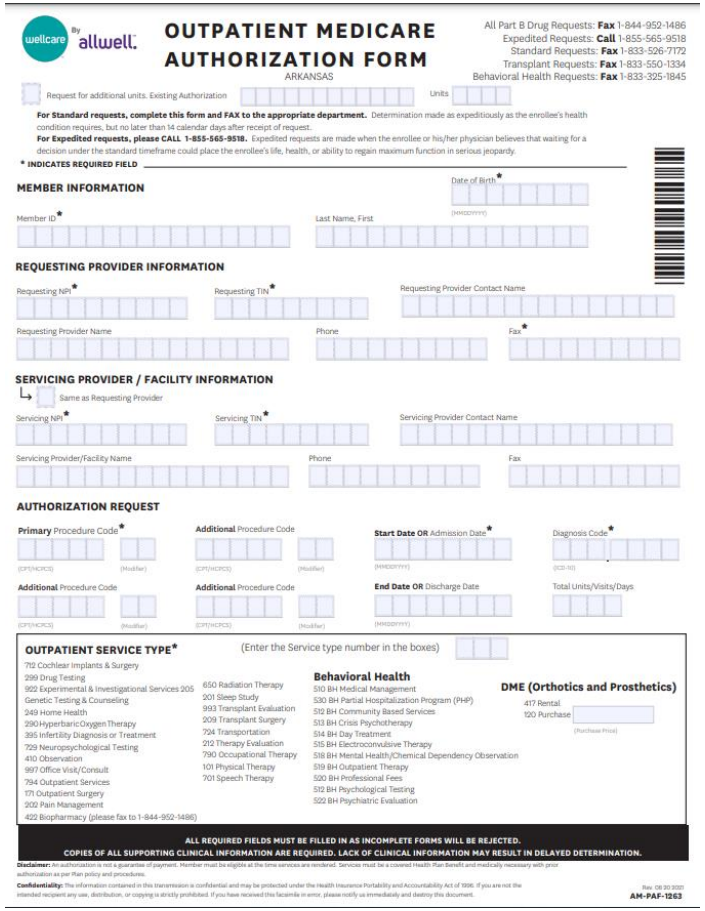
Service Type	Timeframe
Elective/scheduled admissions	Required five business days prior to the scheduled admit date
Emergent inpatient admissions	Notification required within one business day
Emergency room and post-stabilization; urgent care and crisis intervention	Notification requested within one business day

PRIOR AUTHORIZATIONS

Prior authorization is required for:*

- Inpatient admissions, including observation
- Home health services
- Ancillary services
- Radiology — MRI, MRA, PET, CT
- Pain management programs
- Outpatient therapy and rehab (occupational therapy, physical therapy, speech therapy)
- Transplants
- Surgeries
- Musculoskeletal procedures
- Durable Medical Equipment (DME)
- Part B drugs

*This is not an all-inclusive list.



OUTPATIENT MEDICARE AUTHORIZATION FORM

ARKANSAS

All Part B Drug Requests: **Fax** 1-844-952-1486
Expedited Requests: **Call** 1-855-565-9518
Standard Requests: **Fax** 1-833-526-7172
Transplant Requests: **Fax** 1-833-550-1334
Behavioral Health Requests: **Fax** 1-833-325-1845

Request for additional units. Existing Authorization ____ Units ____

For Standard requests, complete this form and FAX to the appropriate department. Determination made as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after receipt of request.
For Expedited requests, please CALL 1-855-565-9518. Expedited requests are made when the enrollee or his/her physician believes that waiting for a decision under the standard timeframe could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

* INDICATES REQUIRED FIELD

MEMBER INFORMATION

Member ID* | Last Name, First | Date of Birth* (MMDDYYYY)

REQUESTING PROVIDER INFORMATION

Requesting NPI* | Requesting TIN* | Requesting Provider Contact Name
Requesting Provider Name | Phone | Fax*

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider

Servicing NPI* | Servicing TIN* | Servicing Provider Contact Name
Servicing Provider/Facility Name | Phone | Fax

AUTHORIZATION REQUEST

Primary Procedure Code* (CPT/HCPCS) (Modifier) | **Additional** Procedure Code (CPT/HCPCS) (Modifier) | **Start Date OR** Admission Date* (MMDDYYYY) | Diagnosis Code* (ICD-10)
Additional Procedure Code (CPT/HCPCS) (Modifier) | **Additional** Procedure Code (CPT/HCPCS) (Modifier) | **End Date OR** Discharge Date (MMDDYYYY) | Total Units/Visits/Days

OUTPATIENT SERVICE TYPE* (Enter the Service type number in the boxes)

712 Cochlear Implants & Surgery
299 Drug Testing
922 Experimental & Investigational Services 205
Genetic Testing & Counseling
249 Home Health
290 Hyperbaric Oxygen Therapy
395 Infertility Diagnosis or Treatment
729 Neuropsychological Testing
410 Observation
997 Office Visit/Consult
794 Outpatient Services
171 Outpatient Surgery
202 Pain Management
422 Biopharmacy (please fax to 1-844-952-1486)
650 Radiation Therapy
201 Sleep Study
993 Transplant Evaluation
209 Transplant Surgery
704 Transportation
212 Therapy Evaluation
790 Occupational Therapy
101 Physical Therapy
701 Speech Therapy

Behavioral Health
510 BH Medical Management
530 BH Partial Hospitalization Program (PHP)
512 BH Community Based Services
513 BH Crisis Psychotherapy
514 BH Day Treatment
515 BH Electroconvulsive Therapy
516 BH Mental Health/Chemical Dependency Observation
519 BH Outpatient Therapy
520 BH Professional Fees
522 BH Psychological Testing
522 BH Psychiatric Evaluation

DME (Orthotics and Prosthetics)
417 Rental
120 Purchase (Purchase Price)

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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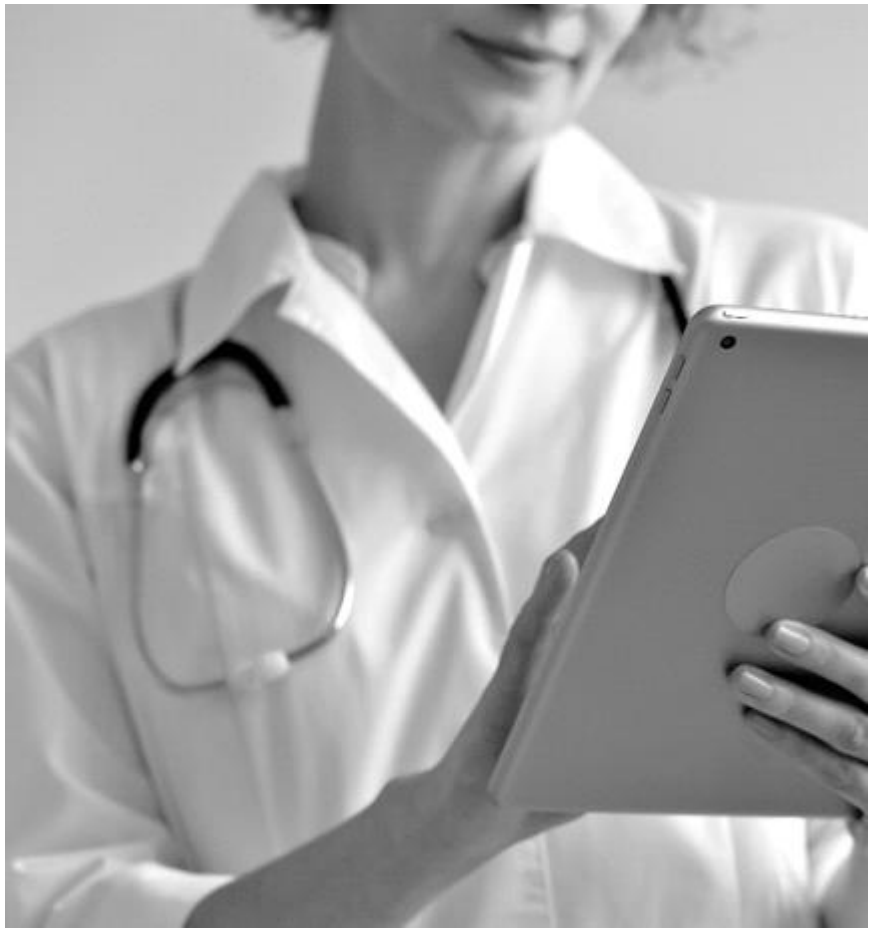
OUT-OF-NETWORK COVERAGE

Plan authorization is required for out-of-network services, except:

- Emergency care.
- Urgently needed care when the network provider is not available (usually due to being out of the area).
- Kidney dialysis at Medicare-certified dialysis center when temporarily out of the service area.



MEDICAL NECESSITY DETERMINATION

When medical necessity cannot be established, a peer-to-peer conversation is offered. Denial letters will be sent to the member and provider. The clinical basis for the denial will be indicated. Member appeal rights will be fully explained.

PREVENTIVE CARE AND SCREENINGS

PREVENTIVE CARE

- No copay for all preventive services covered under original Medicare at zero cost-sharing.
- Initial Preventive Physical Exam — Welcome to Medicare
  - Measurement of height, weight, body mass index, blood pressure, visual acuity screen, and other routine measurements.
  - Includes an electrocardiogram, education, and counseling. Does not include lab tests.
  - Limited to one per lifetime.
- Annual Wellness Visit
  - Available to members after the member has had the one-time initial preventive physical exam.

PREVENTIVE CARE

Abdominal Aortic Aneurysm Screening	Cervical and Vaginal Cancer Screenings	Medical Nutrition Therapy Services
Alcohol Misuse Counseling	Colonoscopy	Medication Review
Blood Pressure Screening	Colorectal Cancer Screenings	Obesity Screening and Counseling
BMI, Functional Status	Depression Screening	Pain Assessment
Bone mass measurement	Diabetes Screenings	Prostate Cancer Screenings (PSA)
Breast Cancer Screening (mammogram)	Fecal Occult Blood Test	Sexually Transmitted Infections Screening and Counseling
Cardiovascular Disease (behavioral therapy)	Flexible Sigmoidoscopy	Tobacco Use Cessation Counseling (counseling for people with no sign of tobacco-related disease)
Cardiovascular Screenings	HIV screening	Vaccines, Including Flu Shots, Hepatitis B Shots, Pneumococcal Shots

MEDICARE STAR RATINGS

MEDICARE STAR RATINGS

What Are STAR Ratings?

- The Centers for Medicare & Medicaid Services (CMS) uses a five-star quality rating system to measure Medicare beneficiaries' experience with their health plans and the healthcare system.
- This rating system applies to Medicare Advantage (MA) plans that cover both health services and prescription drugs (MA-PD).
- The ratings are posted on the CMS consumer website at Medicare.gov to give beneficiaries help choosing an MA and MA-PD plan offered in their area.
- The STAR Rating program is designed to promote improvement in quality and recognize PCPs for demonstrating an increase in performance measures over a defined period of time.

MEDICARE STAR RATINGS

THE CMS STAR RATING PROGRAM IS BASED ON MEASURES IN NINE DOMAINS:

Part C

- Staying healthy: Screenings, tests, and vaccines.
- Managing chronic (long-term) conditions.
- Member experience with the health plan.
- Member complaints, problems getting services, and improvement in the health plan's performance.
- Health plan customer service.

Part D

- Drug plan customer service.
- Member complaints and changes in the drug plan's performance.
- Member experience with the drug plan.
- Drug safety and accuracy of drug pricing.

HOW CAN PROVIDERS IMPROVE STAR RATINGS?

- Continue to encourage patients to obtain preventive screenings annually or when recommended.
- Management of chronic conditions such as hypertension and diabetes including medication adherence.
- Continue to talk to your patients and document interventions regarding topics such as fall prevention, bladder control, and the importance of physical activity and emotional health and well-being — Health Outcomes Survey (HOS).
- Create office practices to identify noncompliant patients at the time of their appointment.
- Follow up with patients regarding their test results — Consumer Assessment of Healthcare Providers and Systems (CAHPS).

HOW CAN PROVIDERS IMPROVE STAR RATINGS?

- Submit complete and correct encounters/claims with appropriate codes and properly document medical chart for all members, including availability of medical record for chart abstractions.
- Review the gap in care files, which list members with open gaps, available on our Secure Provider Portal at Provider.ARHealthWellness.com.
- Review medication and follow up with members within 14 days post-hospitalization.
- Identify opportunities for you or your staff to have an impact on your patient's health and well-being.
- Make appointments available to patients and reduce wait times (CAHPS).

WEB-BASED TOOLS

PUBLIC PROVIDER WEBSITE

From the For Providers page of the Wellcare by Allwell website, providers can access:

- Provider manuals
- Forms
- HEDIS® Quick Reference Guides
- Provider news
- Pre-Auth Needed tool
- Other provider resources

EXPLORE NOW:
Wellcare.ARHealthWellness.com

SECURE PROVIDER PORTAL

Easily access the data and tools you need via our Secure Provider Portal at Provider.ARHealthWellness.com. Features include:

- Authorizations
- Claims
- Download Payments History
- Processing Status
- Claim Submissions/Adjustments
- Clear Claim Connection — Claim Auditing Software
- Health Records
- Care Gaps
- Monthly PCP Cost Reports
- Patient Listings and Member Eligibility

NETWORK PARTNERS

PARTNERS AND VENDORS

Service	Specialty Company/Vendor	Contact Information
High Tech Imaging Services	National Imaging Associates (NIA)	1-866-214-2569 RadMD.com
Vision Services	Envolve Vision Benefits	1-800-334-3937 EnvolveVision.com
Dental Services	Delta Dental	DeltaDentalAR.com/Medicare-Advantage
Pharmacy Services	Envolve Pharmacy Solutions (EPS)	1-888-865-6567 Prior Authorizations: 1-844-202-6824
Orthopedic and Spinal Surgical Procedures	Turning Point	1-866-619-7054

BILLING OVERVIEW

ELECTRONIC CLAIMS TRANSMISSION

- When possible, we recommend using Electronic Data Interchange (EDI) to submit claims and attachments for payment.
- EDI allows for a faster processing turnaround time than paper submissions.
- Wellcare by Allwell partners with six clearinghouses for submission:
  - Availity — Payer ID 68069
  - Emdeon
  - Gateway
  - SSI
  - Medavant
  - Smart Data Solution

NEED EDI SUPPORT?

- For more information about EDI, contact:

Wellcare by Allwell
c/o Centene EDI Department
1-800-225-2573 ext. 6075525
EDIBA@centene.com

CLAIMS SUBMISSION TIMELINES

- Medicare Advantage claims can be mailed to the following billing address:

  Wellcare by Allwell
  Attn: Claims
  P.O. Box 3060
  Farmington, MO 63640-3822

- Participating providers have 180 days from the date of service to submit a timely claim.

- All requests for reconsideration or claim disputes must be received within 180 days of the original date of notification of payment or denial.

CLAIMS PAYMENT

- A clean claim is received in a nationally accepted format in compliance with standard coding guidelines and requires no further information, adjustment, or alteration for payment.
- A claim will be paid or denied, and an Explanation of Payment (EOP) will be mailed to the provider who submitted the original claim.
- Providers may **not** bill members for services when the provider fails to obtain authorization and the claim is denied.
- Dual-eligible members are protected by law from balance billing for Medicare Parts A and B services. This includes deductibles, coinsurance, and copayments.
- Providers may **not** balance bill members for any differential.

ELECTRONIC FUNDS TRANSFER (EFT)
ELECTRONIC REMITTANCE ADVICE (ERA)

- Electronic payments can mean faster payments, leading to improvements in cash flow.
- Eliminate re-keying of remittance data.
- Match payments to statements quickly.
- Providers can quickly connect with any payers that are using PaySpan Health to settle claims.
- Free service for network providers at PaySpanHealth.com.

CODING AUDITING & EDITING

Wellcare by Allwell uses code editing software based on a variety of edits:

- American Medical Association (AMA).
- Specialty society guidance.
- Clinical consultants.
- Centers for Medicare & Medicaid Services (CMS).
- National Correct Coding Initiative (NCCI).
- Software audits for coding inaccuracies such as:
  - Unbundling
  - Upcoding
  - Invalid codes

CLAIMS RECONSIDERATION & DISPUTES

A claim dispute is to be used only when a provider has received an unsatisfactory response to a request for reconsideration.

Submit reconsiderations or disputes to:

Reconsideration	Claim Dispute
Wellcare by Allwell	Wellcare by Allwell
Attn: Level I — Request for Reconsiderations	Attn: Level II — Claim Dispute
P. O. Box 3060	P.O. Box 4000
Farmington, MO 63640-5010	Farmington, MO 63640-5000

MEANINGFUL USE: ELECTRONIC MEDICAL RECORDS

MEANINGFUL USE

- The exchange of patient data between healthcare providers, insurers, and patients is critical to advancing patient care, data security, and the healthcare industry as a whole.
- Electronic Health Records/Electronic Medical Records (EHR/EMR) allow healthcare professionals to provide patient information electronically instead of using paper records.
- EHR/EMR can provide many benefits, including:
  - Complete and accurate information.
  - Better access to information.
  - Patient empowerment.

(Incentive programs may be available.)

ADVANCE DIRECTIVES

ADVANCE MEDICAL DIRECTIVES

- An advance directive will help providers understand a member's wishes about their healthcare in the event they become unable to make decisions on their own behalf. Examples include:
  - Living wills
  - Healthcare power of attorney
  - "Do Not Resuscitate" orders
- Execution of an advance directive must be documented on the member's medical records.
- Providers must educate staff on issues concerning advance directives and maintain written policies that address a member's right to make decisions about their own medical care.

REGULATORY INFORMATION

MEDICARE OUTPATIENT OBSERVATION NOTICE (MOON)

- Contracted hospitals and critical access hospitals must deliver the Medicare Outpatient Observation Notice (MOON) to any member who receives observation services as an outpatient for more than 24 hours.
- The MOON is a standardized notice to a member informing them that they are an outpatient receiving observation services and not an inpatient of the hospital or critical access hospital.
- The MOON must be delivered no later than 36 hours after observation services are initiated, or sooner upon release.
- The approved MOON form and instructions is available at CMS.gov/Medicare/Medicare-General-Information/BNI.

FRAUD, WASTE, AND ABUSE

FRAUD, WASTE, AND ABUSE

Wellcare by Allwell follows the four parallel strategies of the Medicare and Medicaid programs to prevent, detect, report, and correct fraud, waste, and abuse:

- Preventing fraud through effective enrollment and education of physicians, providers, suppliers, and beneficiaries.
- Detection through data analytics and medical records review.
- Reporting any identified or investigated violations to the appropriate partners, including contractors, the NBI-MEDIC, and federal and state law enforcement agencies such as the Office of Inspector General (OIG), Federal Bureau of Investigation (FBI), Department of Justice (DOJ), and Medicaid Fraud Control Unit (MFCU).
- Correcting fraud, waste, or abuse by applying fair and firm enforcement policies such as pre-payment review, retrospective review, and corrective action plan.

FRAUD, WASTE, AND ABUSE

Wellcare by Allwell performs front- and back-end audits to ensure compliance with billing regulations. The most common errors include:

- Use of incorrect billing codes.
- Not following the service authorization.
- Procedure code not being consistent with provided service.
- Excessive use of units not authorized by the case manager.
- Lending of insurance card.

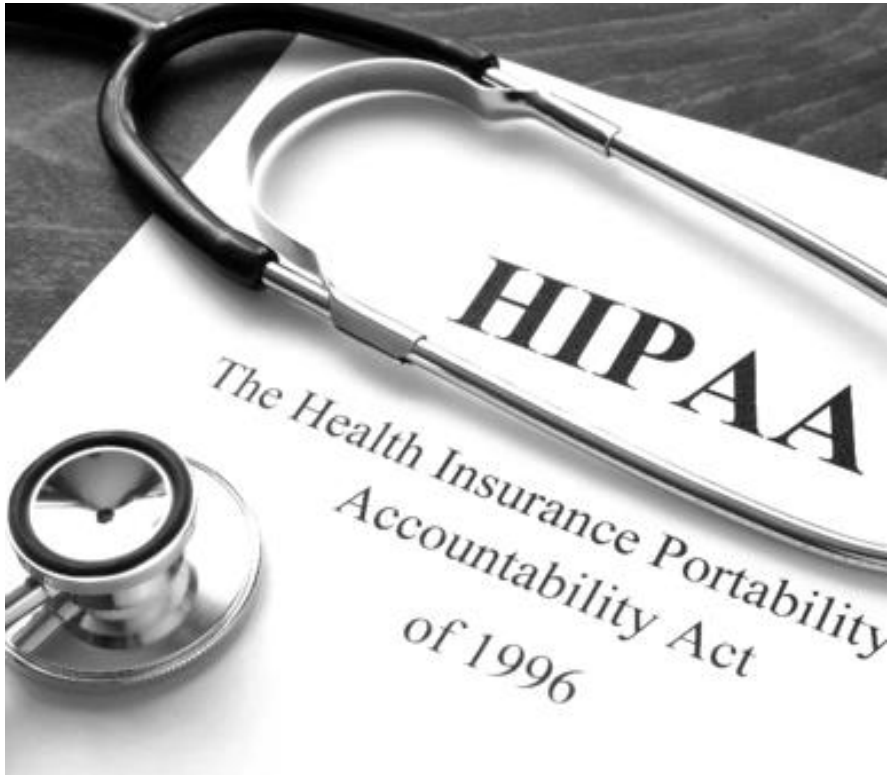
Benefits of stopping fraud, waste, and abuse:

- Improves patient care.
- Helps save dollars and identify recoupments.
- Decreases wasteful medical expenses.

FRAUD, WASTE, AND ABUSE

Wellcare by Allwell expects all providers, contractors, and subcontractors to comply with applicable laws and regulations, including the following:

- Federal and State False Claims Act
- Qui Tam Provision (Whistleblower)
- Anti-Kickback Statute
- Physician Self-Referral Law (Stark Law)
- Health Insurance Portability and Accountability Act (HIPAA)
- Social Security Act (SSI)
- U.S. Criminal Codes



MEDICARE REPORTING

- Potential fraud, waste, or abuse reporting may be called in to our anonymous and confidential hotline at
  1-866-685-8664, or by contacting the Compliance Officer at:

  Wellcare by Allwell

  Attn: Compliance Officer

  P.O. Box 25438

  Little Rock, AR 72221
- To report suspected fraud, waste, or abuse in the Medicare program, please use one of the following avenues:
  - Office of Inspector General (HHS-OIG): 1-800-447-8477 (TTY: 1-800-377-4950)
  - Fax: 1-800-223-8164
  - NBI MEDIC: 1-877-7SafeRx (1-877-772-3379)
  - Web: OIG.HHS.gov/Fraud
  - Email: HHSTips@oig.hhs.gov
  - Medicare's Arkansas Fraud Hotline: 1-800-633-4227 (TTY: 1-877-486-2048)

CMS MANDATORY TRAININGS

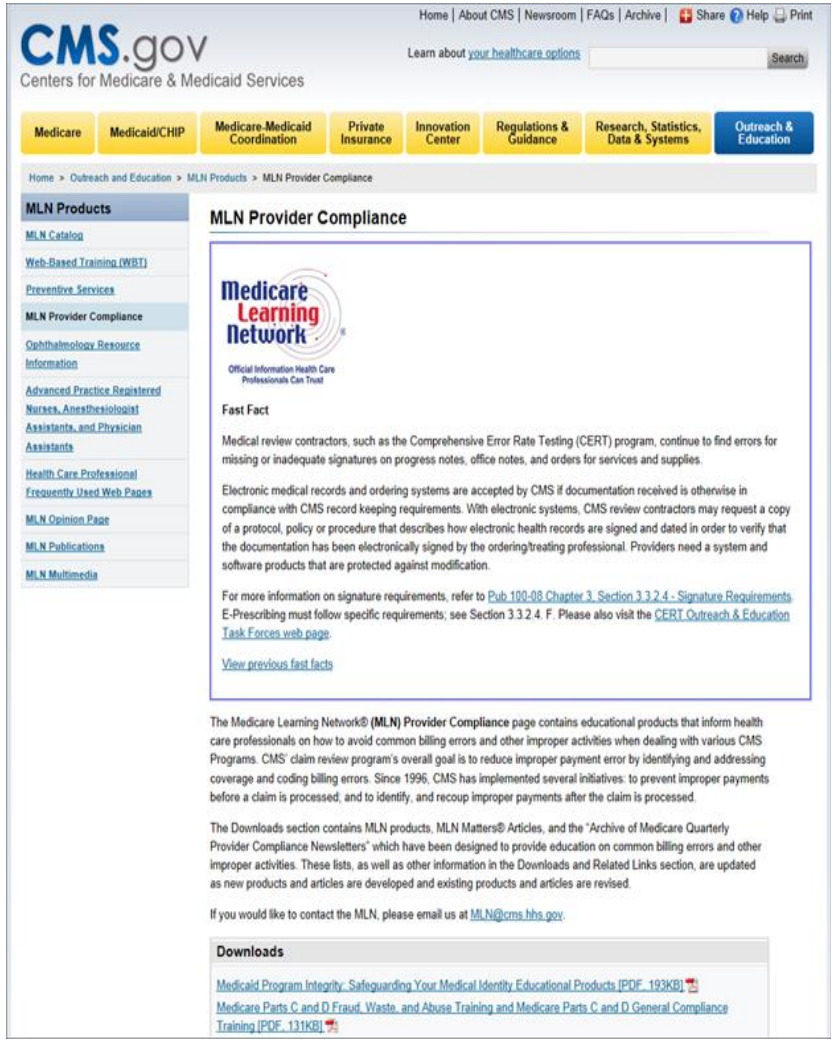
CMS MANDATORY TRAININGS

All Wellcare by Allwell contracted providers, contractors, and subcontractors are required to complete three required trainings:

- General Compliance (Compliance): Within 90 days of joining Wellcare by Allwell and annually thereafter.
- Fraud, Waste, and Abuse (FWA): Within 90 days of joining Wellcare by Allwell and annually thereafter.

GENERAL COMPLIANCE & MEDICARE FRAUD, WASTE, AND ABUSE TRAINING

- Providers are required to complete training via the Medicare Learning Network (MLN) website.
- Training must be completed by each individual provider/practitioner within the group. One person cannot represent the group.
- Training must be completed within 90 days of contracting and annually thereafter.
- Copies of certificate(s) of completion or attestation earned through the CMS MLN must be provided to Wellcare by Allwell.



GENERAL COMPLIANCE & FRAUD, WASTE, AND ABUSE TRAININGS

- First-Tier, Downstream, and Related Entities (FDR), as well as delegated entities, are required to complete training via the MLN website.
- The trainings must be completed by each individual provider/practitioner within the group.
- The updated regulation requires all applicable entities (providers, practitioners, and administrators) to complete the training within 90 days of contracting or becoming a delegated entity, and annually thereafter.
- Once training is complete, each applicable entity must complete the certificate(s) of completion or attestation through the CMS MLN and provide a copy to Wellcare by Allwell.

Q&A

Confidential and Proprietary Information

WLCR22-AR-H-009