wellcare By allwell.™

Meet Wellcare by Allwell.

2026 Provider Orientation

Agenda

- Plan Overview
- Key Resources for Providers
- Membership, Benefits, & Additional Services
- Providers and Authorizations
- Preventive Care and Screenings
- Model of Care (SNP plans only)
- Medicare Star Ratings
- Web Based Tools
- Network Partners
- Billing Overview
- Electronic Funds Transfer & Electronic Medical Records
- Advance Directives
- Fraud, Waste, & Abuse
- CMS Mandatory Trainings

Plan Overview

Meet Wellcare by Allwell

Welcome to Wellcare by Allwell!

- Wellcare by Allwell is the Medicare brand for Centene Corporation, a leading healthcare enterprise committed to helping people live healthier lives. Today, Wellcare by Allwell is proud to offer access to quality, affordable, and culturally sensitive healthcare to more than 1 million Medicare Advantage members and 4.1 million PDP members across all 50 states.
- We believe this change makes things easier for members, brokers, and providers like you.
- Our goal is to ensure your patients receive the best care.

The Strength of Wellcare by Allwell

Our experience and commitment to these programs enable us to serve our members and providers as well as manage operations effectively and efficiently.

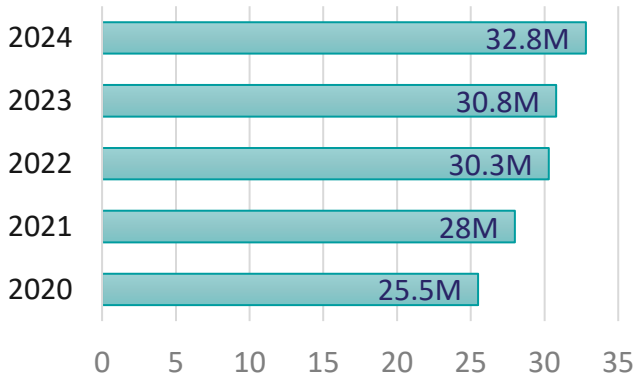
- Local management with national expertise
- Full continuum of Medicare products including:
  - HMO
  - PPO
  - DSNP
  - MMP

1.1M
Medicare members across **32 STATES**

358K
Special Needs Plan members across **30 STATES**

4.1M
Prescription Drug Plan members across **50 STATES**

Total Medicare Advantage Members Nationwide



7.1%
Avg. YoY Growth Medicare Advantage Enrolled

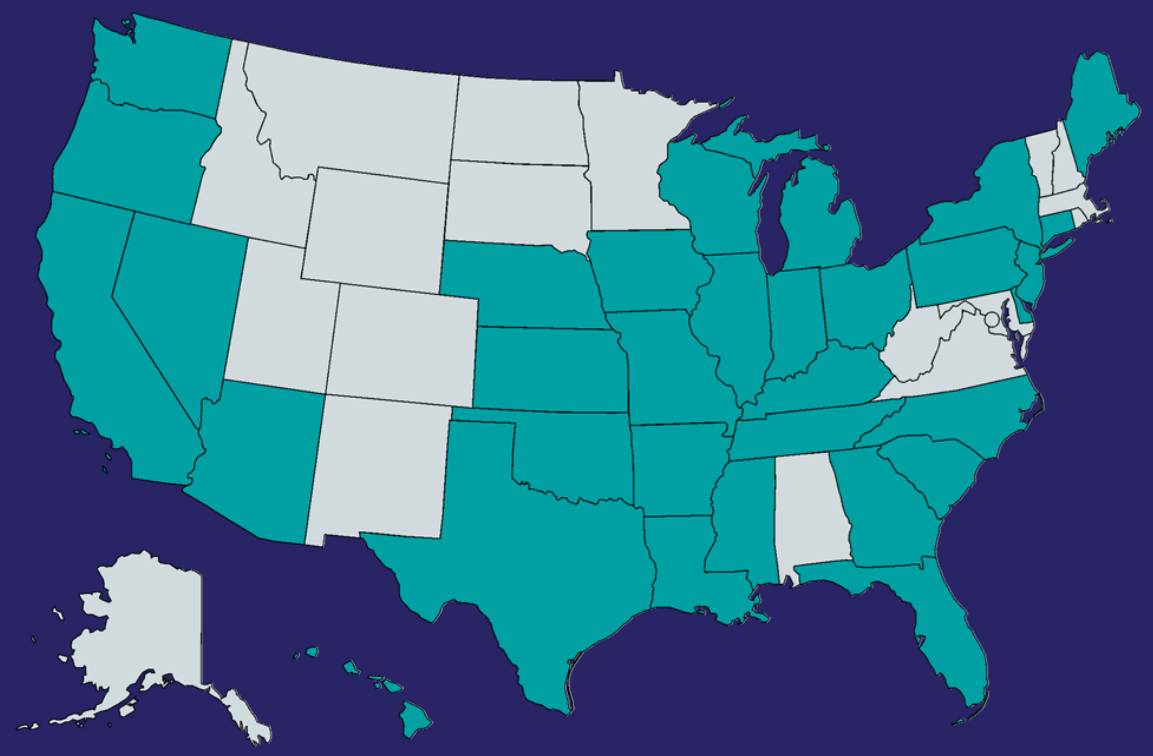
32.8M
Medicare Advantage enrolled members nationwide

50.2%
Medicare Advantage Penetration Rate nationwide

1.1 Million Medicare Members

#6
largest MA plan

#1
largest MAPD plan



Who We Are

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)**

Additional Services

- **Telehealth** — Doctors are available by teleconference day and night, and on weekends and holidays.
- **Free In-Home Support & Chore Services** — Available services to keep members' homes safe and clean, including help with light cleaning, household chores, and meal prep.
- **Free Transportation** — Free trips to doctor's offices and pharmacies with some plans eligible for non-medical transportation.
- **OTC Allowances** — Members receive annual over-the-counter (OTC) allowances and pay $0 for certain OTC products, depending on the plan.
- **24-Hour Nurse Advice Line** — Speak with a live nurse, 24 hours a day, any day of the year.
- **Digital Social Support Platform** — Focuses on members behavioral health and social support.

Our Whole Health Approach

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

This includes:

- Integrated coordination care
- Care management
- Co-location of behavioral health expertise
- Integration of pharmaceutical services with the 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 — all co-located in a single, locally based unit.

We Are Proud to Be Your Medicare Advantage Partner

As our partner, you can count on Wellcare by Allwell to provide:

- Fast and accurate claims payments
- Efficient and convenient processes for providing care to our members
- Responsive Provider Engagement representatives to assist with all your needs

We are committed to working with you to ensure your patients receive the quality, affordable healthcare they deserve.

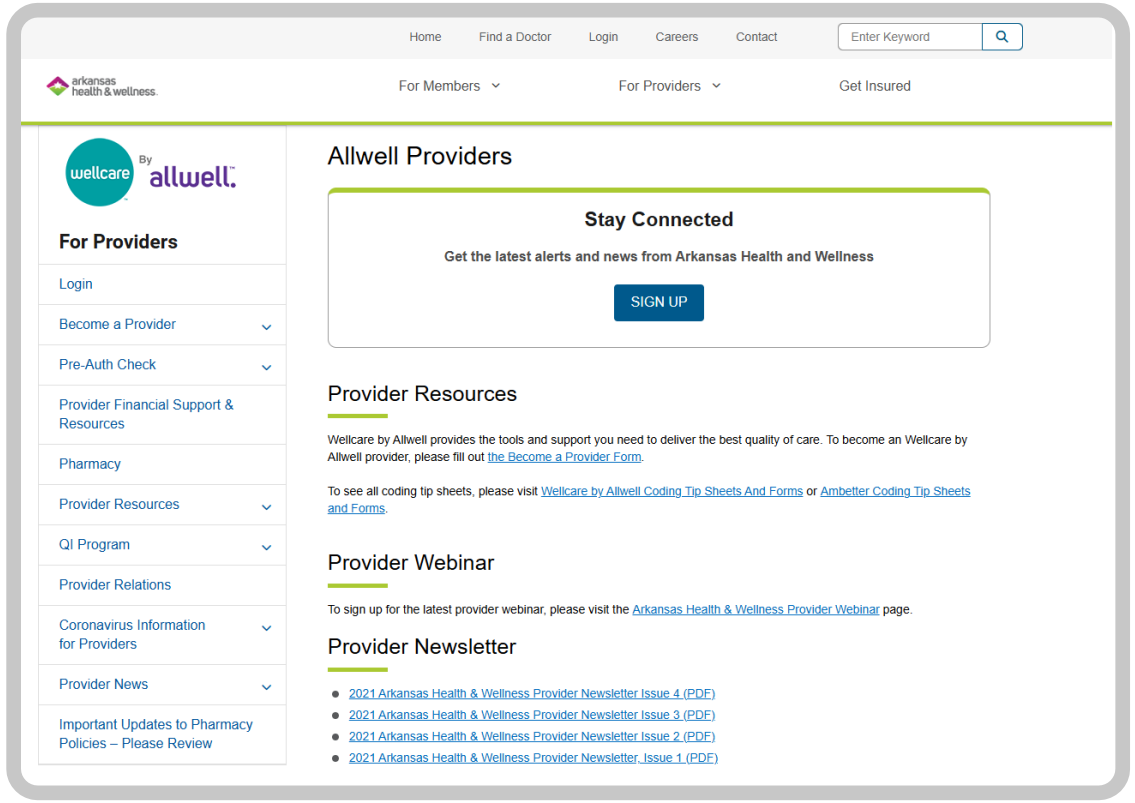
Key Resources for Providers

Key Contact Information

Phone
1-855-538-0454 (TTY: 711)

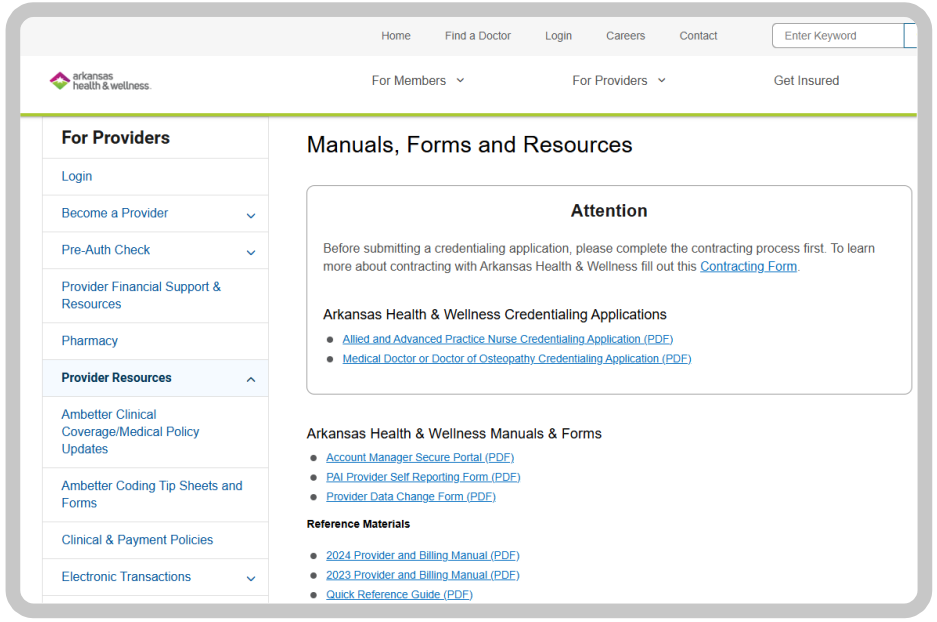
Web
Wellcare.ARHealthWellness.com

Portal
Provider.ARHealthWellness.com



Provider Manual

The Provider Manual is your comprehensive guide to doing business with Wellcare by Allwell.



The manual includes a wide array of important information relevant to providers, such as:

- Network information
- Billing guidelines
- Claims information
- Regulatory information
- Key contact list
- Quality initiatives

The Provider Manual can be found in the For Providers section of the Wellcare by Allwell website at www.arhealthwellness.com/providers/allwell-providers.html

Provider Services

Our Provider Services team includes trained staff available to respond quickly and efficiently to all provider inquiries or requests including, but not limited to:

- Credentialing/Network status
- Claims
- Request for adding/deleting physicians to an existing group

By calling Provider Services at **1-855-538-0454,** providers can access real-time assistance for all their service needs.

Provider Engagement

As a Wellcare by Allwell provider, you will have a dedicated Provider Engagement Specialist available to assist you.

Our Provider Engagement Specialists serve as the primary liaisons between our health plan and provider network.

Your Provider Engagement Specialist is here to help you operate your practice and address needs:

- Inquiries related to administrative policies, procedures, and operational issues
- Performance pattern monitoring
- Contract clarification
- Membership/provider roster questions
- Provider education
- Secure Portal registration and PaySpan Health
- HEDIS®/care gap reviews
- Financial analysis
- EHR utilization
- Demographic information updates
- Initiate credentialing of a new practitioner

Membership, Benefits, & Additional Services

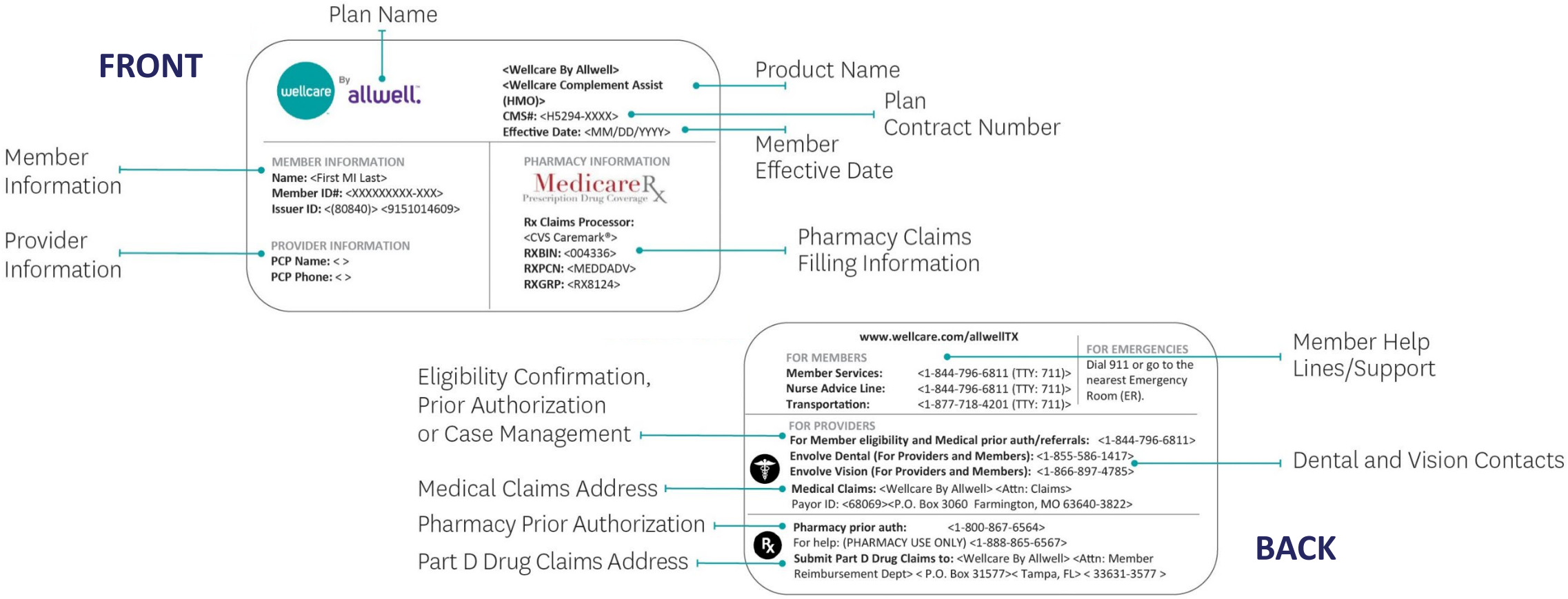
Membership

Assignment of Primary Care Provider
Most members will choose a PCP or have one assigned to them by Wellcare by Allwell.

Verifying Member Benefits, Eligibility, and Cost Shares
A member's eligibility status may change at any time. Therefore, all providers should verify eligibility, benefits, and cost sharing prior to each scheduled appointment. Providers should also request members to present their ID card, along with additional proof of identification such as a photo ID (if applicable), at each encounter

- Providers should verify eligibility before every visit by using one of the below options:
  - Website: Wellcare.ARHealthWellness.com
  - Provider Services: 1-855-538-0454 (TTY: 711)

Member ID Cards



Plan Coverage

Medicare Advantage covers:

Part A — Hospital Coverage

- Inpatient care in hospitals
- Skilled nursing facility care
- Hospice care
- Home healthcare

Part B — Medical Coverage

- Services from doctors and other healthcare providers
- Outpatient care
- Home healthcare
- Durable medical equipment (like wheelchairs, walkers, hospital beds, and other equipment)
- Many preventive services (like screenings, shots/ vaccines, and annual preventive visits)

Medicare Advantage (also known as Part C)

- An “all in one” alternative to Original Medicare that includes Part A, Part B and, usually, Part D.
- Plans may have lower out-of-pocket costs than Original Medicare.
- Most plans offer extra benefits that Original Medicare doesn't cover, such as vision, hearing, dental, and more.

Part D — Prescription Drug Coverage

- Cost of prescription drugs (including many recommended shots and vaccines)
- Part D plans are run by private insurance companies that follow rules set by Medicare.

*DSNP plans may have a deductible.

Pharmacy Formulary

- The Advantage formulary is available at: Wellcare.ARHealthWellness.com/drug-pharmacy/formulary.html
- 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 can be found on the health plan website.
- The completed form can be faxed to the Pharmacy Prior Authorization department using the fax number on the form.

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 & Supplies
- Appropriate Cancer Screening Exams
- Appropriate Clinical Screening Exams
- Initial Preventive Physical Exam — Welcome to Medicare
- Annual Wellness Visit
- Therapy Services
- Chiropractic Services
- Podiatric Services

Additional Benefits

HEARING SERVICES

- $0 copay for one routine hearing test every year
- $0 copay for one hearing aid fitting evaluation every year
- Up to $500 per ear every year. Limited to two non-implantable hearing aids every year

DENTAL SERVICES

- Two oral exams per year with no copay
- Two cleanings per year with no copay
- Additional services are available and outlined in the member's Evidence of Coverage (EOC)

**Dental, vision, and hearing benefits vary by plan. Plans can have the same service area but different benefits.*

Additional Benefits (continued)

VISION SERVICES

- One routine eye exam every year
- Unlimited pairs of prescription eyewear every year up to a maximum benefit of $200 every year

**Dental, vision, and hearing benefits vary by plan. Plans can have the same service area but different benefits.*

OVER-THE-COUNTER ITEMS

- Commonly used over-the-counter items — listing available at: Wellcare.ARHealthWellness.com/member-resources/member-perks/otc-benefit.html
- Conveniently shipped to member's home within 5–12 business days
- Members should use the app or member portal

Additional Benefits (continued)

- NurseWise
  - Free health information line staffed with registered nurses 24/7 to answer health questions
- Certified fitness program at specified gyms at no extra cost (availability may vary by plan)

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 **1-844-428-2224 (TTY: 711)**

NON-EMERGENCY TRANSPORTATION

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

Medical Home &
Prior Authorization

Primary Care Physicians (PCP)

- PCPs serve as a “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 member to a covering practitioner
  - Live individual who will contact a PCP

Prior Authorizations

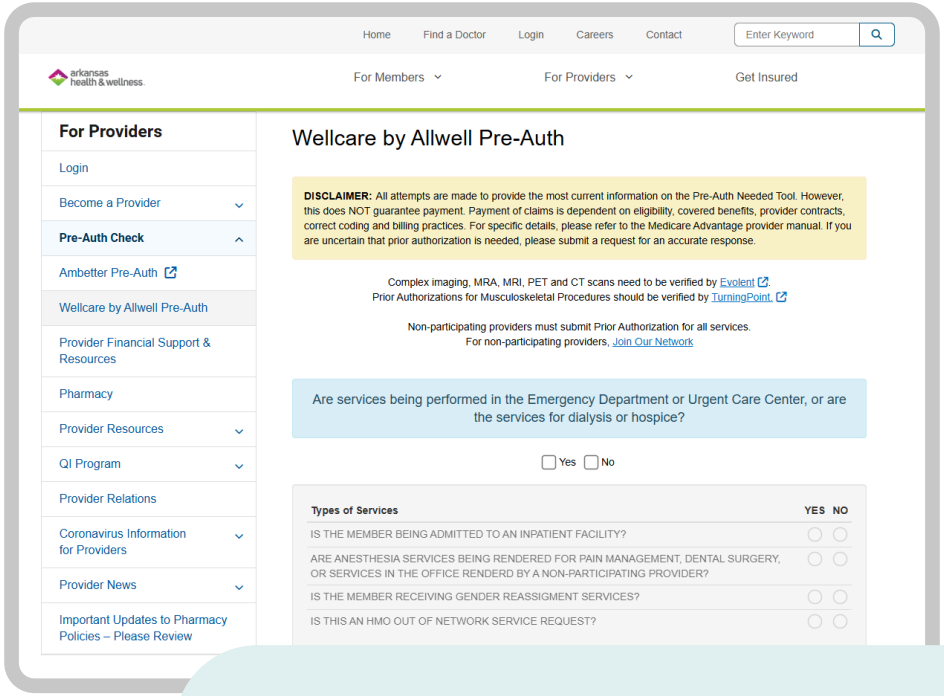
- Authorization must be obtained prior to the delivery of certain elective and scheduled services
- The preferred method for submitting authorization requests is through the Secure Web Portal at Provider.ARHealthWellness.com

Service Type	Time Frame
Elective/scheduled admissions	Required five calendar days prior to the scheduled admit date
Emergent inpatient admissions	Notification required within one business day
Emergency room and post stabilization	Notification requested within one business day

Prior Authorization Requirements

Prior authorization is required for:

- Inpatient admissions
- Home health services
- Ancillary services
- Radiology — MRI, MRA, PET, CT
- Pain management programs
- Outpatient therapy and rehab (OT/PT/ST)
- Transplants
- Surgeries
- Durable Medical Equipment (DME)
- Part B drugs



The authorization look-up tool can be found here:
ARHealthWellness.com/providers/preauth-check/medicare-pre-auth.html

Out-of-Network Coverage

- Prior authorization is required for out-of-network services, except:
  - Emergency care
  - Urgently needed care when the network provider is unavailable (usually due to out-of-area)
  - Kidney dialysis at Medicare-certified dialysis centers, when the member is 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 & Screening Tests

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. Also 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 the one-time initial preventive physical exam (Welcome to Medicare Physical).

Preventive Care (continued)

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

Model of Care

Special Needs Plans (SNPs)

Model of Care

- Wellcare by Allwell's Model of Care plan delivers our integrated care management program for members with special needs
- Applies to Dual Special Needs Plan (D-SNP) and Chronic Condition Specials Needs Plan (C-SNP) members

- The goals of our Model of Care are:
  - Improve access to medical, behavioral health, and social services
  - Improve access to affordable care
  - Improve coordination of care through an identified point of contact
  - Improve transitions of care across healthcare settings and providers
  - Improve access to preventive health services
  - Assure appropriate utilization of services
  - Assure cost-effective service delivery
  - Improve beneficiary health outcomes

Model of Care Elements

- Description of the SNP population (D-SNP and C-SNP)
- Care coordination, transitions of care, and interdisciplinary care team protocol
- Provider network
- Quality measurement

Model of Care Process

- We contact every SNP member to complete a Health Risk Assessment (HRA) within 90 days of enrollment and annually thereafter, or more frequently if there is a significant change in health status.
- The HRA collects information about the member's medical, psychosocial, cognitive, functional and social determinate needs, and medical and behavioral health history. The HRA is scored for risks to assist with triage.
- A member's HRA risk level helps to determine the appropriate level of care management and composition of an Interdisciplinary Care Team (ICT).
- At a minimum, every member is provided an annual Individualized Care Plan (ICP) outlining health goals and interventions.
- Each member receives an annual in-person or virtual face-to-face encounter with a provider or Wellcare by Allwell care coordination staff to support care management and coordination.

Model of Care Process *(continued)*

- Wellcare by Allwell values our partnership with our physicians and providers.
- The Model of Care requires all of us to work together to benefit our members by:
  - Enhanced communication between members, providers, and health plan care management staff.
  - Interdisciplinary Care Team (ICT) approach tailored to the member's medical, behavioral, and social needs.
  - Comprehensive coordination with all care partners including PCPs, specialists, and community supports.
  - Support for the member's preferences and goals as in documented in the Individualized Care Plan (ICP).
  - Reinforcement of the member's connection with their PCP and medical home.

Medicare Star Ratings

Medicare Star Ratings

What Are CMS Star Ratings?

- CMS uses a five-star rating system to evaluate Medicare Advantage plans based on quality of care, Member satisfaction, and performance metrics.
- Star Ratings are published annually on Medicare.gov to help beneficiaries compare Medicare Advantage and Part D plans. The Star Rating program promotes continuous quality improvement and recognizes Providers for improving member outcomes and adherence to preventive care guidelines.

Star Rating Program Measures

PART C

1. Staying healthy through preventive screenings, tests, and vaccinations
2. Managing chronic conditions such as diabetes, hypertension, and cardiovascular disease
3. Member experience with the health plan
4. Member complaints, problems getting services and improvement in the health plan's performance
5. Health plan customer service

PART D

1. Drug plan customer service
2. Member complaints and changes in the drug plan's performance
3. Member experience with the health plan including access to care and satisfaction
4. Drug safety, adherence, 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 (HOS).
- Create office practices to identify noncompliant patients at the time of their appointment.
- Follow up with patients regarding their test results (CAHPS).

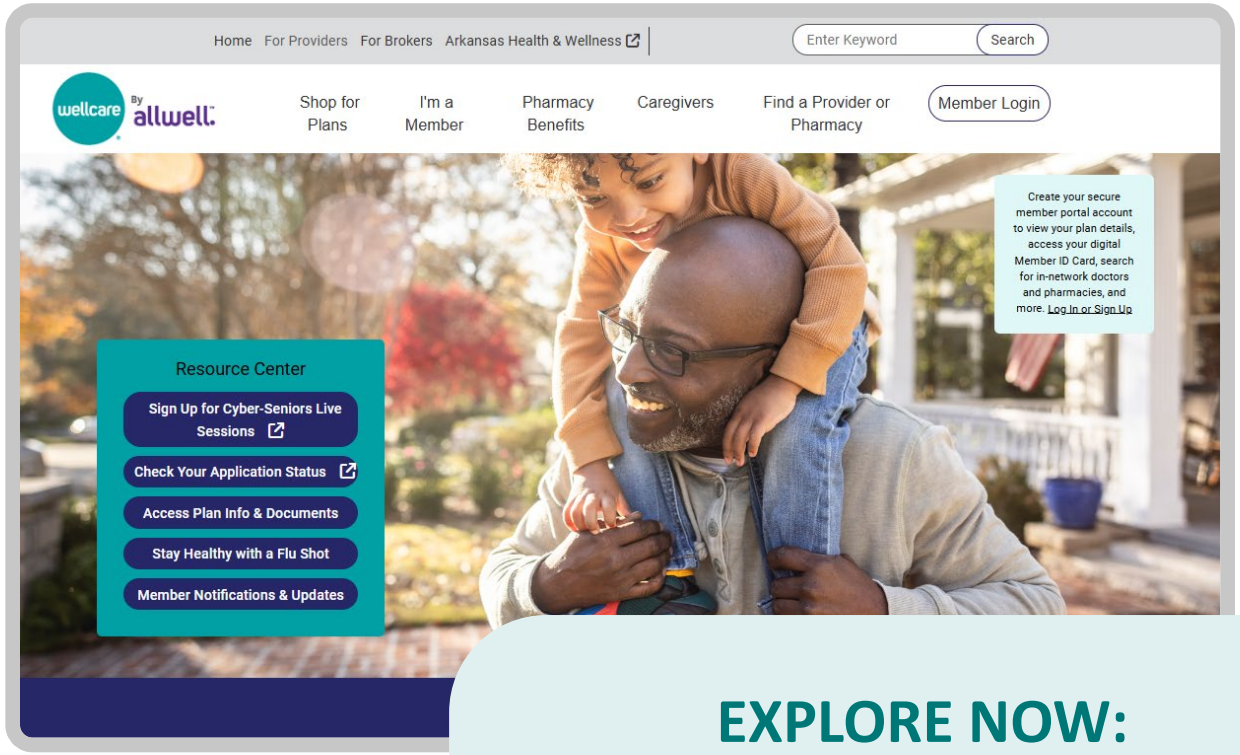
Web-Based Tools

Wellcare.ARHealthWellness.com

Public Provider Website

Through the provider page on the Wellcare by Allwell website, providers can access:

- Provider Manuals
- Forms
- HEDIS Quick Reference Guides
- Provider news
- Pre-Auth Check tool
- Provider resources

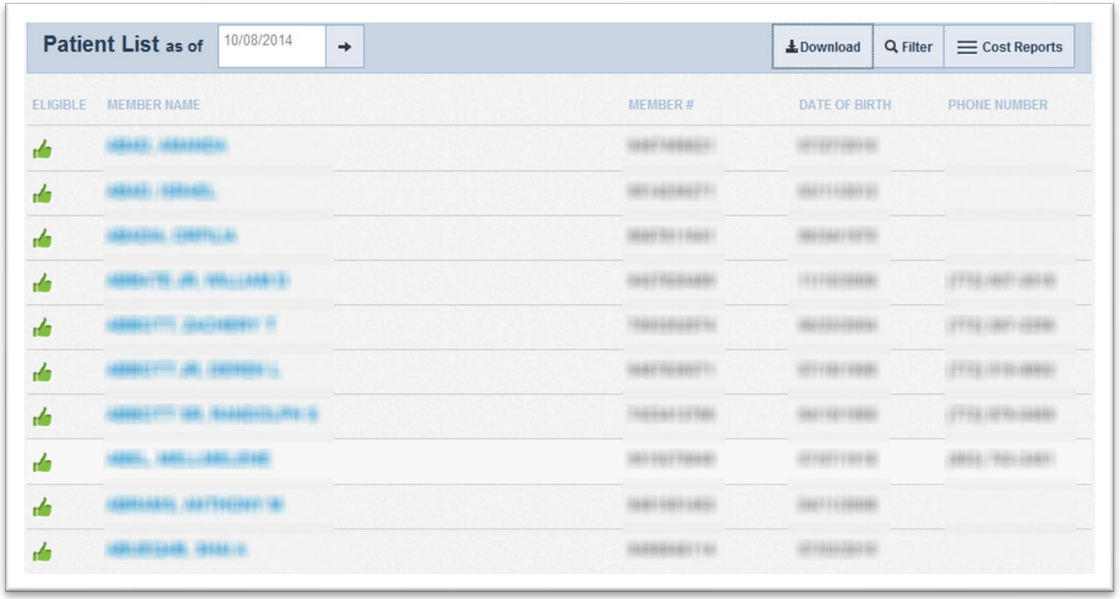


EXPLORE NOW:
Wellcare.ARHealthWellness.com

Primary Care Provider Reports

Patient List

- Located on the Secure Provider Portal at Provider.ARHealthWellness.com
- Includes member's name, ID number, date of birth, and telephone number
- Available to download to Excel or PDF formats and includes additional information such as member's effective date, termination date, product, gender, and address



Members With Frequent ER Visits

Located on the Secure Provider Portal at Provider.ARHealthWellness.com

- This report includes members who frequently visit the ER on a monthly basis.
- The report is available in Excel and PDF formats and provides member information, paid (ER) provider information, claim number, procedure information, diagnosis, and cost information.

PCP Cost Reports

High-Cost Claims

- Located on the Secure Provider Portal at Provider.ARHealthWellness.com
- This report includes members with high-cost claims.
- The report is available in Excel and PDF formats, and provides detailed member information, provider information, claim number, procedure information, diagnosis, and cost information.

PCP Cost Reports *(Continued)*

Rx Claims Report

- Located on the Secure Provider Portal at Provider.ARHealthWellness.com
- This report includes members with pharmacy claims on a monthly basis.
- The report is available in Excel and PDF formats, provides detailed member information, provider information, detailed prescription information (such as pharmacy, units, days refill, etc.), and cost information.

Availity Essentials

Centene has chosen Availity Essentials as its new secure provider portal. Providers can validate eligibility and benefits, submit claims, check claim status, submit authorizations, and access payer resources via Availity Essentials. A phased rollout schedule by state goes through Q1 2025.

- Our current secure portal is still available for other functions that providers use today. For providers new to Availity Essentials, getting their Essentials account is the first step toward working on Availity.
- The provider organization's designated Availity administrator is the person responsible for registering their practice in Essentials, managing user accounts, and should have legal authority to sign agreements for their organization.
- Administrators can register with Availity Essentials here:
  - Availity.com/documents/learning/LP_AP_GetStarted
  - Providers needing additional assistance with registration can call Availity Client Services at 1-800-AVAILITY (282-4548), Monday through Friday, 8 a.m.–8 p.m. ET.
- For general questions, providers can reach out to their health plan Provider Engagement Representative.

Network Partners

Partners and Vendors

Service	Specialty Company/Vendor	Contact Information
High Tech Imaging Services	Evolent	1-800-424-5388 RadMD.com
Vision Services	Premier Vision	1-833-883-2336
Dental Services	Liberty	1-888-352-0129

Billing Overview

Electronic Claims Transmission

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

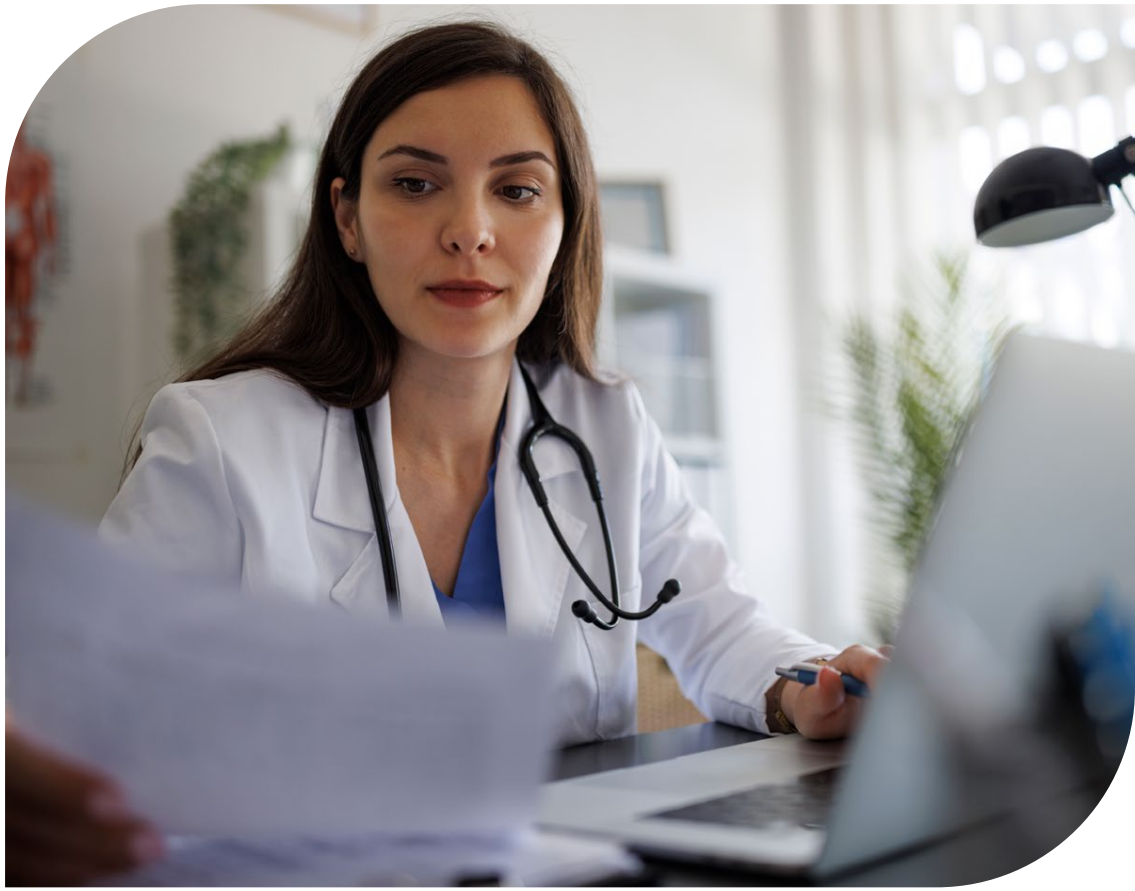
Need EDI Support?

Companion guides for EDI billing requirements plus loop segments can be found on the Wellcare by Allwell website at **ARHealthWellness.com/providers/resources/forms-resources.html**

For more information about EDI, contact:

Wellcare by Allwell
c/o Centene EDI Department

Email: EDIBA@centene.com



Claims Submission Timelines

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

  Wellcare by Allwell

  Attn: Claims Department

  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** from 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 with an Explanation of Payment (EOP) mailed to the provider who submitted the original claim.
- Providers may **not** bill members for Covered Services denied due to lack of authorization unless the member was informed in writing beforehand and agreed to pay.
- Dual-eligible members with QMB/QMB+ status must not be balance billed for Medicare Parts A and B cost-share amounts. Providers must accept the health plan's payment as payment in full.
- 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.
- Providers can register using PaySpan's enhanced Provider registration process at PaySpanHealth.com. For support, contact ProviderSupport@PaySpanHealth.com or call 1-877-331-7154.

Coding Auditing & Editing

Wellcare by Allwell uses claims editing software programs that incorporate CMS guidelines, AMA guidance, and specialty society recommendations to ensure proper coding and prevent improper billing practices:

- American Medical Association (AMA)
- Specialty society guidance
- Clinical consultants
- Centers for Medicare & Medicaid Services (CMS)
- National Correct Coding Initiative (NCCI)
- Software audits identify improper billing practices including :
  - Unbundling
  - Upcoding
  - Excessive units
  - 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.

Contracted providers can submit claims payment disputes by submitting a reconsideration form within **180 days** from the claim determination notice.

Submit reconsiderations or disputes to:

Wellcare by Allwell
Attn: Medicare Appeals
7700 Forsyth Blvd
St. Louis, MO 63105

Meaningful Use:
Electronic Medical Records

Meaningful Use

- The exchange of patient data between healthcare providers, insurers, and patients themselves is critical to advancing patient care, data security, and the healthcare industry.
- Electronic Health Records/Electronic Medical Records (EHRs/EMRs) allow healthcare professionals to provide patient information electronically instead of using paper records.
- Bi-directional EMR data exchange allows payers to share insights directly within the:
  - Provider's EMR
  - Supporting risk adjustment
  - Chronic care management
  - Care gap closure
- 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 the PCP understand the member's wishes about their healthcare in the event they become unable to make decisions on their own behalf. Examples include:
  - Living will
  - Healthcare power of attorney
  - DNR 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.
  - Providers shall not, as a condition of treatment, require a member to execute or waive an Advance Directive.

Regulatory Information

Medicare Outpatient Observation Notice (MOON)

- Contracted hospitals and critical access hospitals must deliver the Medicare Outpatient Observation Notice (MOON). Contracted hospitals and Critical Access Hospitals must deliver the 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 they are an outpatient receiving observation services and not an inpatient of the hospital or critical access hospital and the implications of such status.
- The MOON must be delivered no later than 36 hours after observation services are initiated, or if sooner, upon release.
- The OMB-approved MOON and instructions are available at cms.gov/Medicare/Medicare-General-Information/BNI/index.html

Fraud, Waste, & Abuse

Fraud, Waste, & Abuse

Wellcare by Allwell is committed to the prevention, detection, and reporting of suspected healthcare fraud, waste, and abuse according to applicable federal and state statutory, regulatory, and contractual requirements:

- Preventing fraud through effective enrollment and education of physicians, providers, suppliers, and beneficiaries
- Detection tools have been developed to identify patterns of healthcare service use, including overutilization, unbundling, upcoding, misuse of modifiers, and other common schemes
- 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 plans

Fraud, Waste, & Abuse *(continued)*

Federal and state regulatory agencies, law enforcement, and Wellcare by Allwell vigorously investigate incidents of suspected fraud, waste, and abuse:

- Medical records and other documentation must be legible and support the level of care and service indicated on claims
- Not following the service authorization
- Procedure code not being consistent with provided service
- Providers engaged in fraud, waste, and abuse may be subject to disciplinary and corrective actions, including termination and prosecution

Fraud, Waste, & Abuse *(continued)*

Benefits of stopping fraud, waste, and abuse:

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

Fraud, Waste, & Abuse *(continued)*

Participating providers must comply with all CMS rules and regulations:

- All employees who work for or contract with a Medicaid managed care organization must meet annual compliance and educational training requirements with respect to FWA.
- Providers must check the OIG/GSA Exclusion and CMS Preclusion List prior to hiring or contracting, then monthly thereafter.

Fraud, Waste, & Abuse (continued)

Providers must comply with all applicable federal and state laws including the False Claims Act, Anti-Kickback Statute, HIPAA, and CMS regulations. Annual training and policy updates are required to maintain compliance:

- 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

Fraud, Waste, & Abuse (continued)

Suspected fraud, waste, and abuse can be reported anonymously via Wellcare by Allwell's hotline or directly to the Office of Inspector General (OIG) or NBI MEDIC. Protections are in place for whistleblowers. The hotline phone number is **1-866-685-8664**.

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 Fraud Hotline: **1-800-633-4227**
- Web: **Medicare.gov**

CMS Mandatory Trainings

CMS Mandatory Trainings

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

Model of Care (MOC):

For DSNP and CSNP only, within 30 days of joining Wellcare by Allwell and annually thereafter

General Compliance (Compliance):

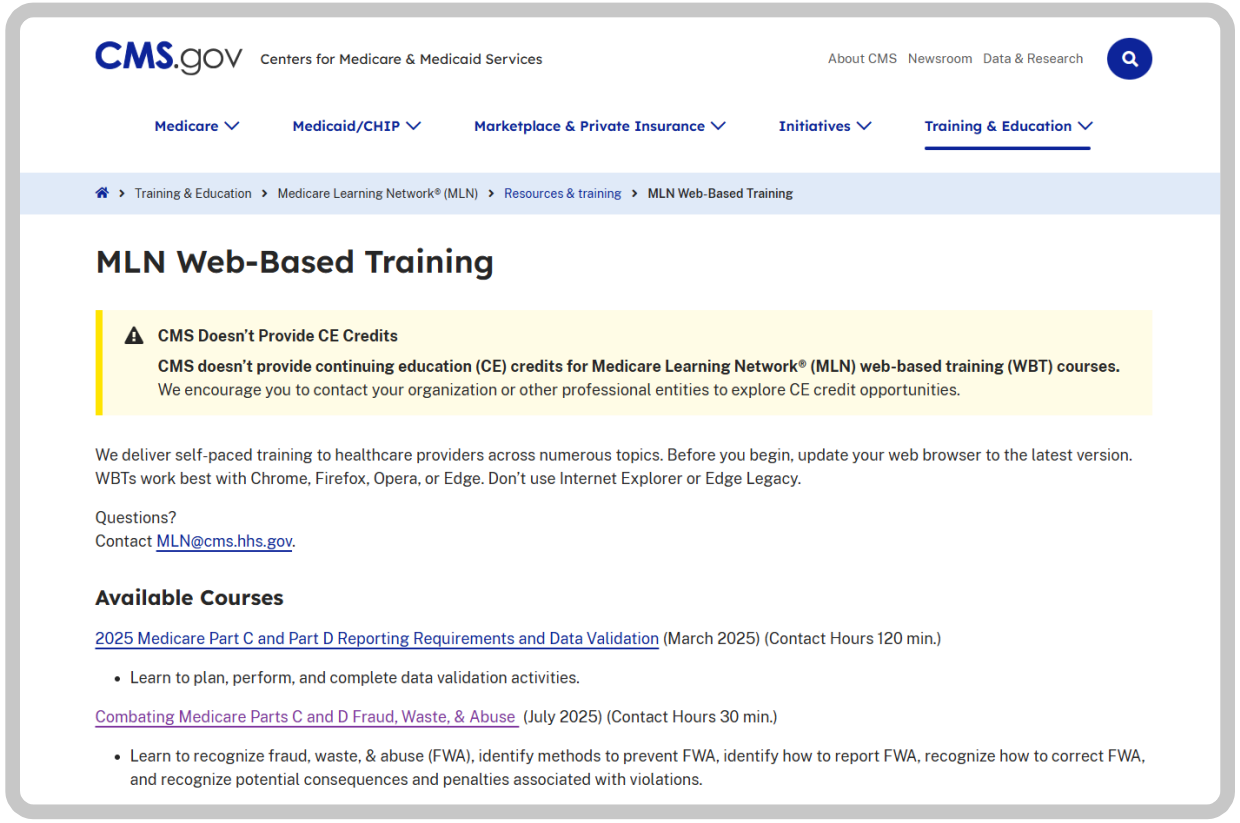
Within 90 days of joining Wellcare by Allwell and annually thereafter

Fraud, Waste, & Abuse (FWA):

Within 90 days of joining Wellcare by Allwell and annually thereafter

Model of Care Training

- Model of Care training is a CMS requirement for any provider that treats SNP members to be completed annually.
- Newly contracted Medicare providers should complete within 30 days of execution of contract.
- Model of Care information is available at CMS.gov/training-education/medicare-learning-networkr-mln/resources-training/mln-web-based-training.



General Compliance & Medicare Fraud, Waste, & Abuse Training

All providers, practitioners, and delegated entities must complete General Compliance and FWA training via the CMS Medicare Learning Network (MLN) within 90 days of contracting and annually thereafter. Each individual must complete the training and submit a certificate or attestation to Wellcare by Allwell.

General Compliance & Medicare Fraud, Waste, & Abuse Training

All First-Tier, Downstream, and Related Entities (FDRs), including delegated entities, must complete General Compliance and FWA training via the CMS MLN website within 90 days of contracting and annually thereafter. Each individual provider, practitioner, administrator, or applicable entity must complete the training and submit a certificate or attestation to Wellcare by Allwell.