2025 Meet Wellcare

SHP 202512151P

Agenda

- Plan Overview
- Internal Partners
- Systems
- Key Resources for Providers
- Membership, Benefits, and 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, and Abuse
- CMS Mandatory Trainings

Plan Overview

Who We Are

Wellcare 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 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 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.

Lines of Business (LOB)

Network participation varies per contract. Verify your line of business with the IPA Administrator or Provider Representative.

Medicare National Network (MNN)

PURPOSE

Corporate-wide initiative to provide WellCare Medicare members access to par Medicare providers anywhere in the country WellCare has a presence at par rates and cost shares.

WHAT HAS CHANGED?

This enhancement allows mapping of Medicare HMO (UXR/UAR) and PPO (TLR) LOBs to the HNN and PNN LOBs

- HNN = HMO National Network
- PNN = PPO National Network
- Members can now select PCPs outside of their state-based LOB

WHAT HAS NOT CHANGED?

- Members are still enrolled in their state-based LOBs (UAR/UXR/TLR), NOT in HNN/PNN
- Authorization requirements have not changed

Key Resources for Providers

Key Contact Information

PHONE

1-855-538-0454

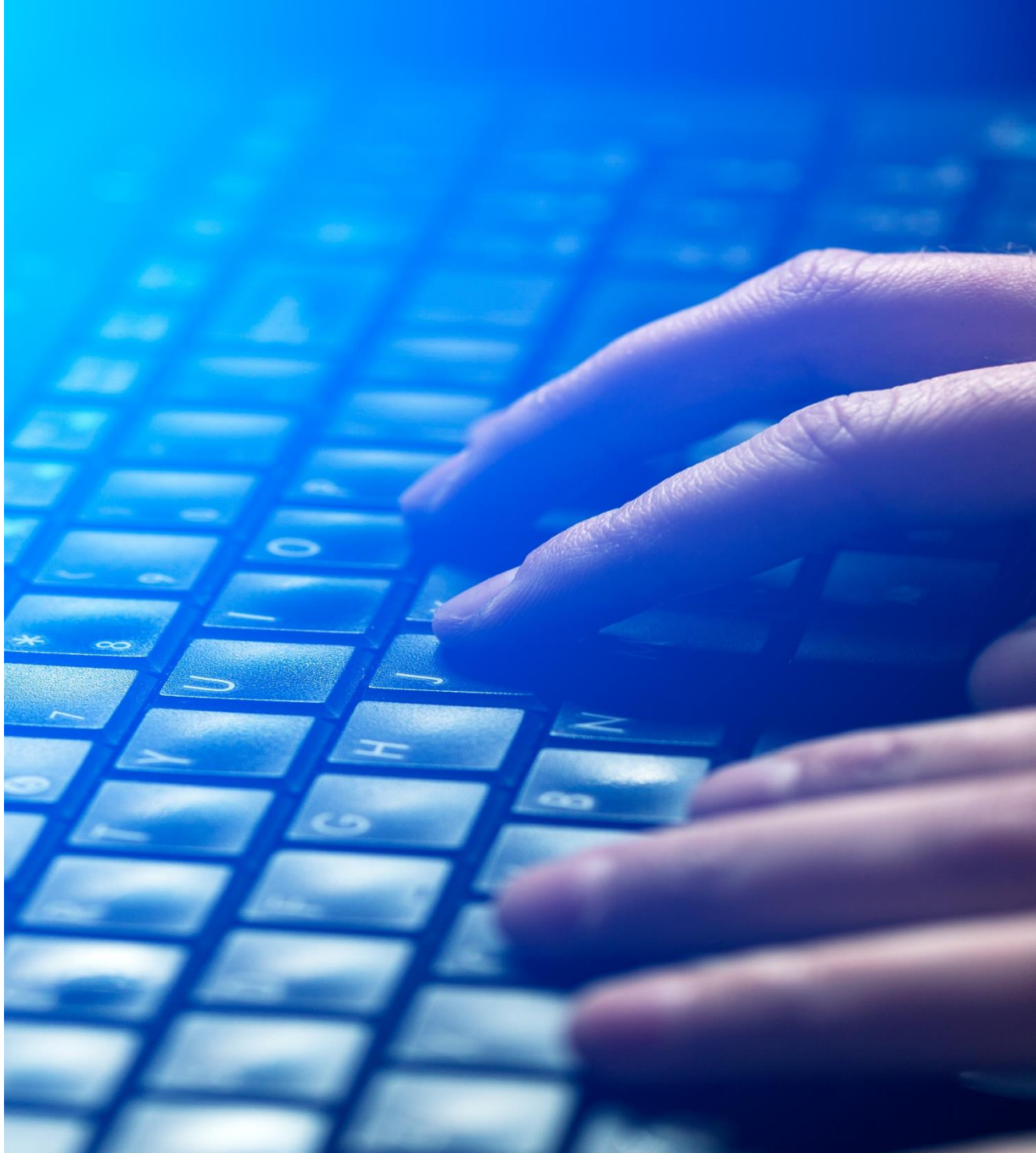
WEB

wellcare.com

PORTAL

WellCare Provider Login

Register and Get Started with Availity Essentials webpage



Provider Manual

- The Provider Manual is your comprehensive guide to doing business with Wellcare
- The manual includes a wide-array of important information relevant to providers that includes:
    - Network information
    - Billing guidelines
    - Claims information
    - Regulatory information
    - Key contact list
    - Quality initiatives
- The Provider Manual can be found in the Provider section of Wellcare's Overview & Resources webpage.

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
  - Verifying providers/member eligibility
- By calling Provider Services at 1-855-538-0454, providers are able to access real time assistance for all their service needs

Provider Representatives

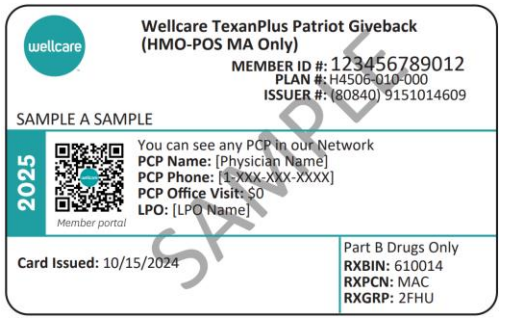
- ✓ Inquiries related to administrative policies, procedures, and operational issues
- ✓ Contract load clarification
- ✓ Membership/provider roster questions
- ✓ Secure Portal registration
- ✓ Secure PaySpan registration
- ✓ Provider education
- ✓ Demographic information updates
- ✓ Terminations
- ✓ Provider Service Queues
- ✓ Submit Salesforce Cases
- ✓ Work Assigned Salesforce Cases
- ✓ Update Grievances
- ✓ Claim Reports

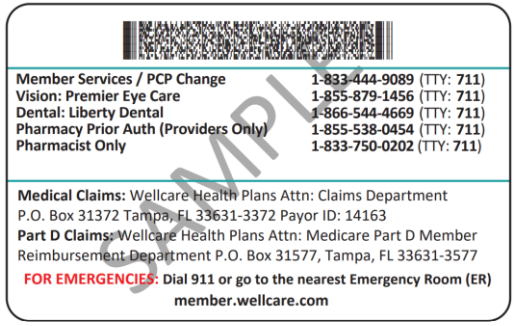
Membership, Benefits, and Additional Services

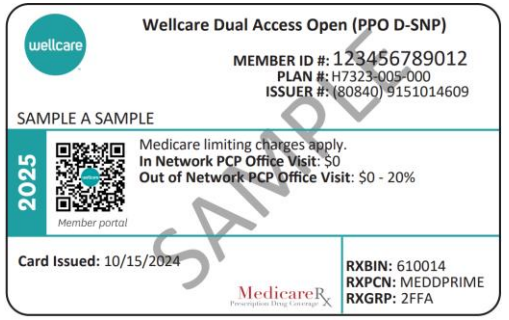
Membership

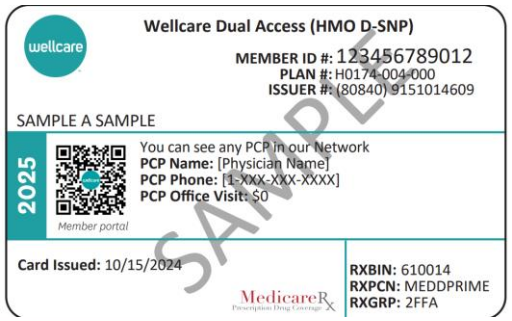
- Medicare beneficiaries have the option to stay in the fee-for-service Original Medicare or choose a Medicare Advantage Plan.
- Advantage members may change PCPs at any time. Changes take effect on the first day of the month.
- Providers should verify eligibility before every visit by using one of the below options:
  - Wellcare's Secure Provider Portal
  - 24/7 Interactive Voice Response Line - 1-800-581-9952
  - Provider Services - 1-855-538-0454

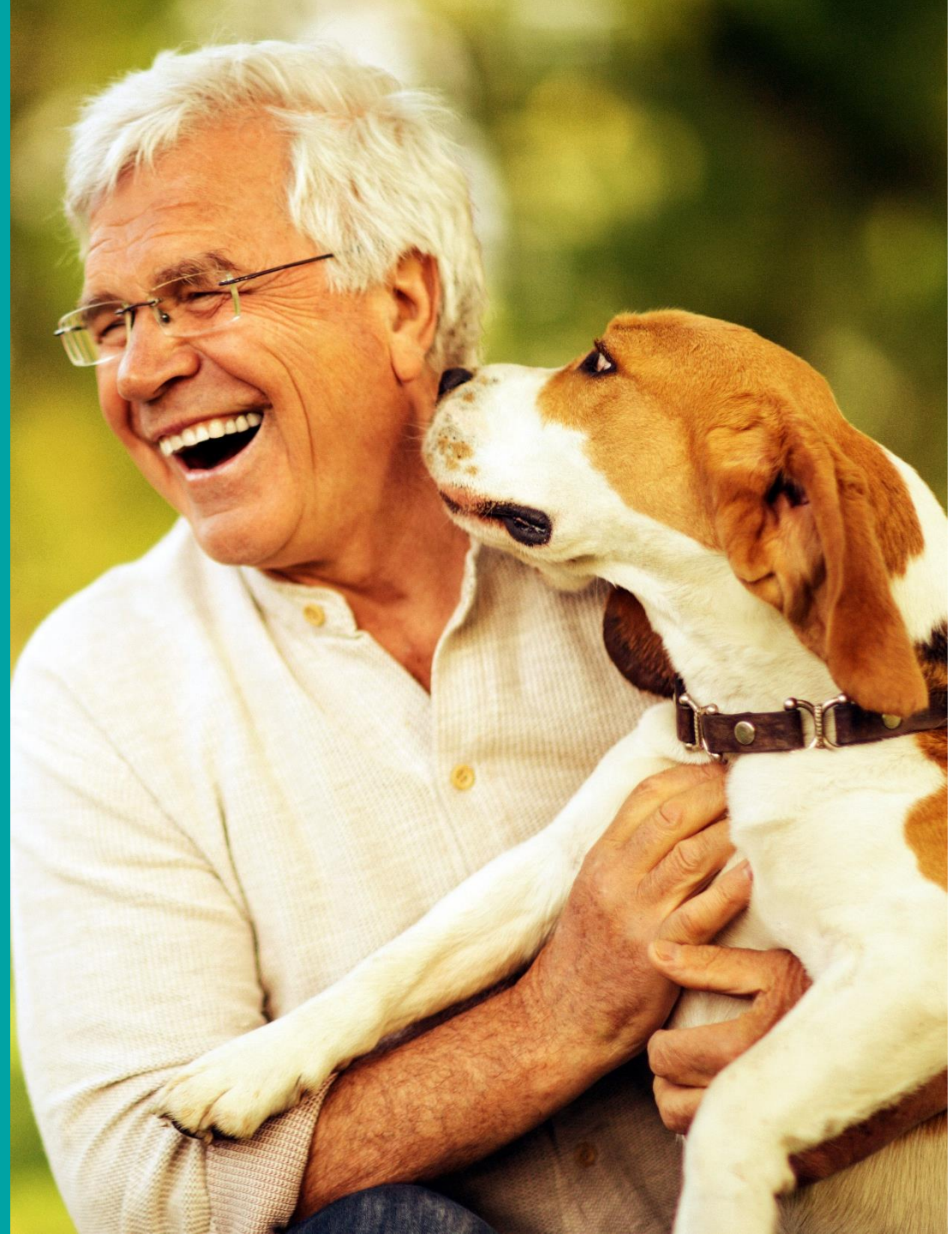
Member ID Cards











Plan Coverage

Medicare Advantage covers:

- **All Part A and Part B benefits by Medicare**
- **Part B drugs – such as chemotherapy drugs**
- **Part D drugs –Part D benefit consists of three phases: annual deductible, initial coverage, and catastrophic coverage. In addition, member's out-of-pocket prescription costs will not exceed $2,000 with the option to pay in the form of monthly payments over the course of the plan year.**
- **Preferred retail pharmacy networks will include Walgreens, CVS, and select grocers. A robust network is expected with more than 60,000 total pharmacies.**
- **Preferred Mail Order service provider is Express Scripts® Pharmacy.**
- **Additional benefits and services such as dental, vision, $0 PCP copay, $0 generics, etc.**

**DSNP plans may have a deductible.*

Pharmacy Formulary

- The Advantage formulary is available on Wellcare's Pharmacy webpage.
- 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 web address provided above.
- 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 Preventative Physical Exam – Welcome to Medicare
- Annual Wellness Visit
- Therapy Services
- Chiropractic Services
- Podiatric Services

Additional Benefits

Hearing Services

Hearing Benefit

- Hearing benefits vary by plan. Plans can have the same service area but different benefits.

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

Dental Services

What's Included in My Dental Benefits?

- Depending on your plan, your dental benefits may include oral exams, cleanings, fluoride treatments, x-rays and emergency services. Some plans also cover dentures.

Additional Benefits

Vision Services

- What's Included in My Vision Benefits?
- Depending on your plan, your vision benefits may include:
  - A yearly routine eye exam
  - Glaucoma prevention care
  - Diabetic eye exams, also called retinal exams
  - Glasses and contacts

**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 on Wellcare's Secure Provider Portal to see what over-the-counter products you can purchase with your Wellcare Spendable card, log in to your secure member portal and click Wellcare Spendable.
- Conveniently shipped to member's home within 5 – 12 Business Days.
- Members should use the App, Website, or call the vendor number at 1-855-256-4620 to order items.

Additional Benefits

- 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

Additional Services

Multi-language Interpreter Services

- Interpreter services are available at no cost to Wellcare members and providers without unreasonable delay at all medical points of contact.
- To get an interpreter, call us at 1-800-225-8017 (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 1-800-225-8017 (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

Adherence to Standards of Timeliness for Appointments & Wait Times

Members can access care according to the following standards:

- Urgently needed services and emergency care: immediately or within 48 hours
- Services that are not emergency or urgently needed but do require medical attention: within one week
- Routine and preventive care: within 30 days
- In-Office Wait Times for ALL standards shall NOT exceed 15 minutes

To ensure that the appointment availability is adhered to, implement the best practices listed below:

This protocol is essential as it illustrates CAHPS and Member Satisfaction.

Appointment	Access standard
URGENT CARE	
Urgent care appointment **with PCP**	Within **48 hours** of request
Urgent care appointment **with SCP (prior approval needed)**	Within **96 hours** of request
Urgent care appointment **with non-physician mental health provider**	Within **48 hours** of request
NON-URGENT	
Non-urgent care appointment **with PCP**	Within **10 business days** of request
Non-urgent care appointment **with SCP**	Within **15 business days** of request
Non-urgent care appointment **with non-physician mental health provider**	Within **10 business days** of request
Appointment for **ancillary services**	Within **15 business days** of request
First prenatal visit[2]	Within **2 weeks** of request
Well-child visit[2]	Within **10 business days** of request
Wellness check[2]	Within **30 calendar days** of request

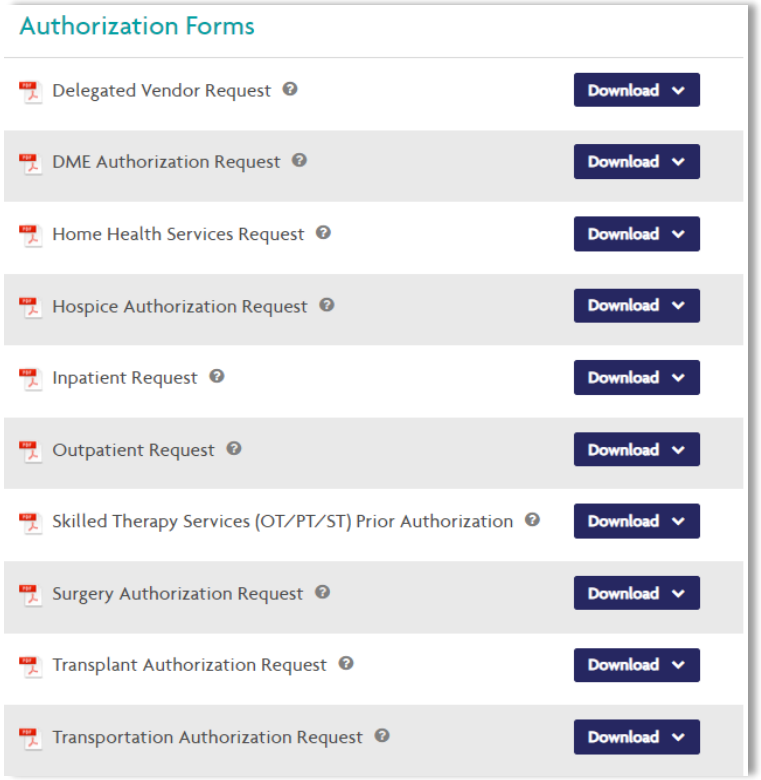
Prior Authorizations

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

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



For more information, please use the Wellcare Authorization Lookup tool.

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 Preventative 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 preventative physical exam (Welcome to Medicare Physical).

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

Model of Care

(DSNP and CSNP only)

Model of Care

- Wellcare's Model of Care plan delivers our integrated care management program for members with special needs
- Only applies to Dual Special Needs Plan (DSNP) and Chronic Condition Specials Needs Plan (CSNP) members
- The goals of our Model of Care are:
  - Improve access to medical, mental 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
- ✓ Care coordination and care transitions protocol
- ✓ Provider network
- ✓ Quality measurement

Model of Care Process

- We contact every DSNP and CSNP member to evaluate their health status with a comprehensive Health Risk Assessment (HRA) within 90 days of enrollment, and at a minimum annually, or more frequently with any significant change in condition or health risk level.
- 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.
- Members 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 with care coordination staff for the purpose of delivering health care, care management, or care coordination services.

Model of Care Process

- Wellcare values our partnership with our members and providers.
- The Model of Care requires all of us to work together to benefit our members by:
  - Enhanced communication between members, physicians, providers, and Wellcare.
  - Interdisciplinary approach to the member’s special needs.
  - Comprehensive coordination with all care partners.
  - Support for the member's preferences in the Model of Care.
  - Reinforcement of the member’s connection with their medical home.

Medicare Star Ratings

Medicare Star Ratings

What are CMS 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 plans that cover both health services and prescription drugs (MA-PD).
- The ratings are posted on the CMS consumer website, to give beneficiaries help in choosing an MA and MA-PD plan offered in their area. The Star Rating program is designed to promote improvement in quality and recognize primary care providers for demonstrating an increase in performance measures over a defined period of time.

Star Rating Program Measures

Part C

1. Staying healthy: screenings, tests and vaccines
2. Managing chronic (long-term) conditions
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 drug plan
4. 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 members 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 members at the time of their appointment.
- Follow up with patients regarding their test results (CAHPS).

Web-Based Tools

WELLCARE'S PROVIDER WEBPAGE

Public Provider Website

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

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

EXPLORE NOW:

Wellcare's Provider webpage

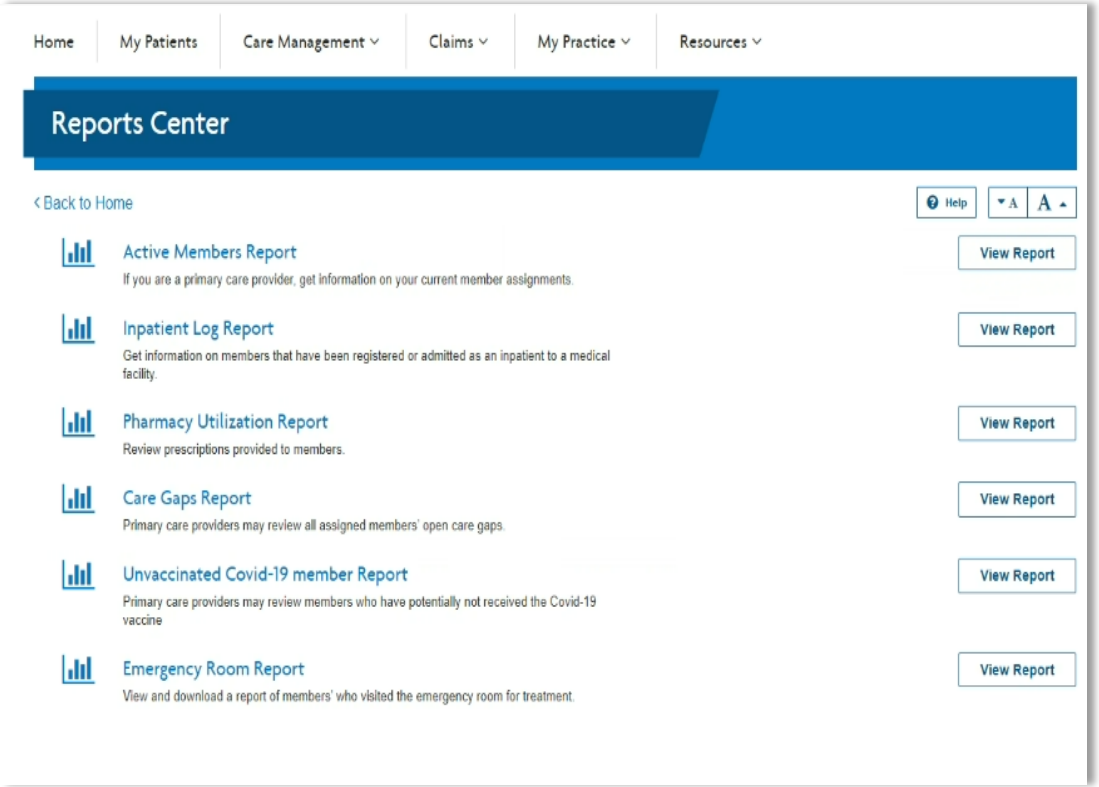
Provider Directory Updates

- Providers can improve member access to care by ensuring that their data is current in our provider directory.
- To update your provider data:
  - Delegated providers email your rosters to POCPLFIntake@wellcare.com
  - Non-Delegated providers email your roster ***ADDs*** to ProspectivProviderTX@wellcare.com
  - Non-Delegated providers email your ***CHANGES*** and ***TERMS*** to your assigned provider representative.

Primary Care Provider Reports

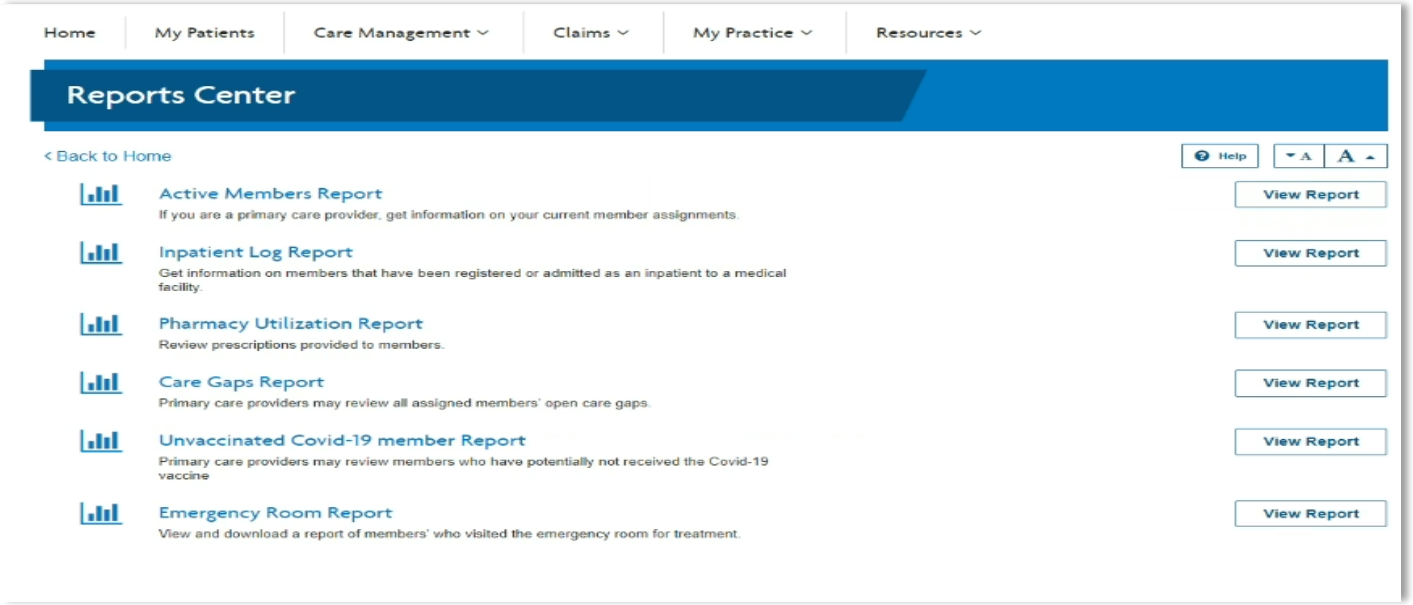
Patient List

- Located on Wellcare's Secure Provider Portal.
- 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

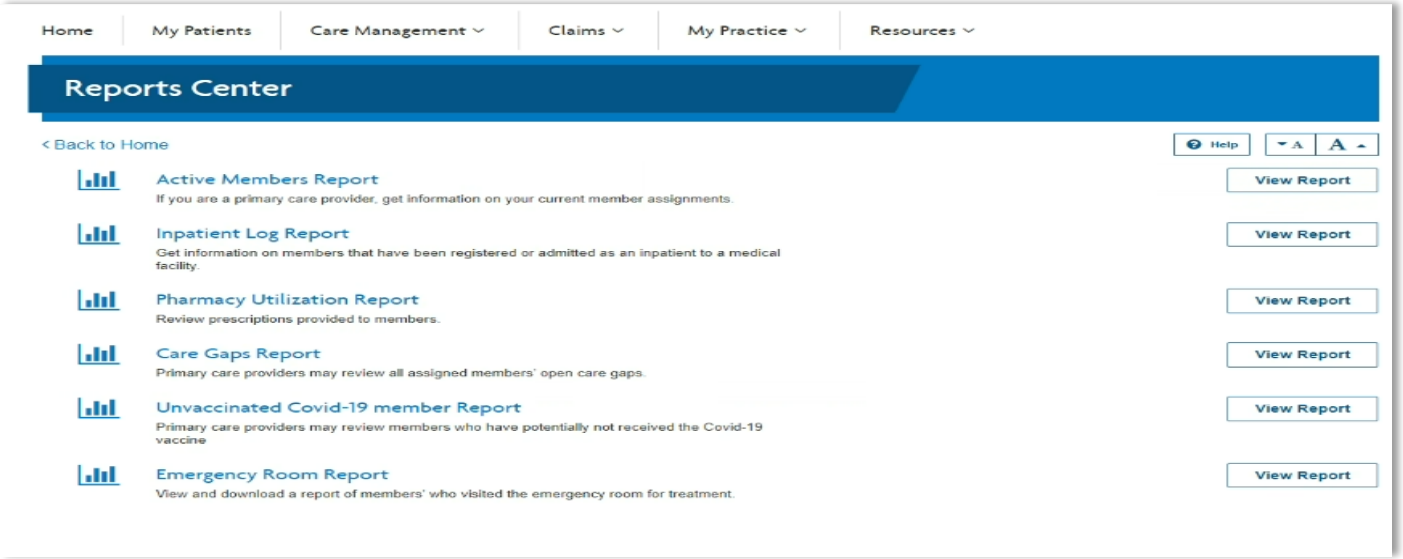
- Located on Wellcare's Secure Provider Portal.
- This report includes members who frequently visit the ER on a monthly basis.
- The report is available in Excel and PDF formats, and provides member information, paid (ER) provider information, claim number, procedure information, diagnosis, and cost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



PCP Cost Reports

High Cost Claims

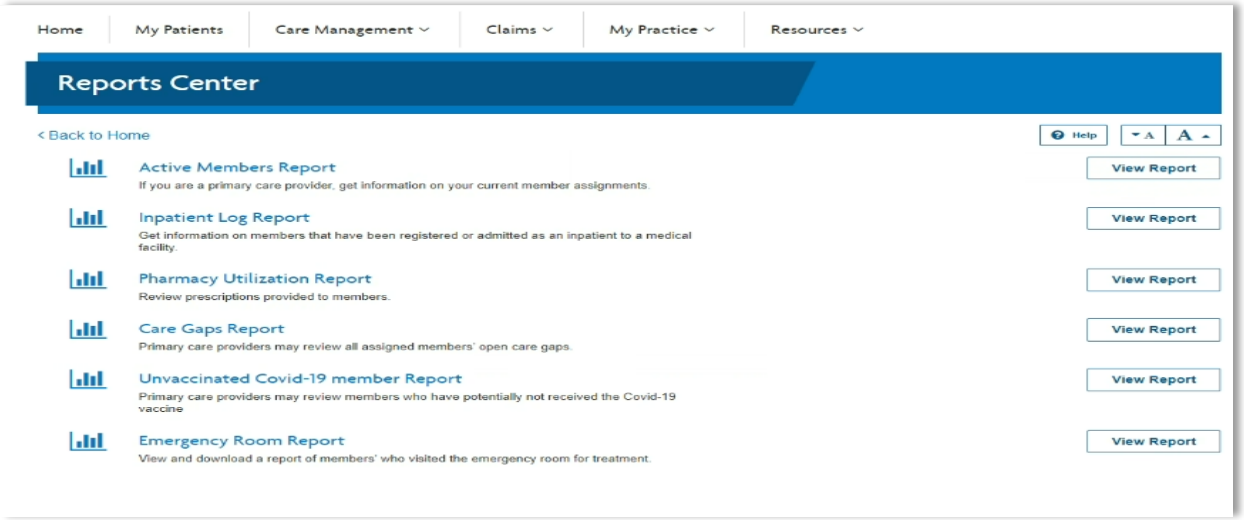
- Located on Wellcare's Secure Provider Portal.
- This report includes members with high-cost claims.
- The report is available in Excel and PDF formats, and provides detailed member information, provider information, claim number, procedure information, diagnosis, and cost information.



PCP Cost Reports

Rx Claims Report

- Located on Wellcare's Secure Provider Portal.
- 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:
  - **Register with Alvaility Essentials webpage**
  - 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 Representative.

Network Partners

Partners and Vendors

Service	Specialty Company/Vendor	Contact Information
High Tech Imaging Services	Evolent	1-800-424-5388 Evolent website
Vision Services	Premier	1-855-879-1456 Premier Eye Care website
Dental Services	Liberty	1-866-544-4669 Liberty Dental Plan website
Pharmacy Services	Express Scripts	1-833-750-0201 Express Scripts® Pharmacy webpage

DME and Lab Partners

DME	
180 Medical	J&B Medical
ABC Medical	KCI
American Home Patient	Lincare
Apria	Hanger Prosthetics and Orthotics
Breg	National Seating & Mobility
CCS Medical	Numotion
Critical Signal Technologies	Shield Healthcare
DJO	St. Louis Medical
EBI	Tactile Medical
Edge Park	Zoll

Lab	
Bio Reference	Diatherix Laboratories, LLC
Sequenome Center	Ambry Genetics Corp.
MD Labs	Natera, Inc.
Lab Corp	Myriad Genetic Laboratories
Quest	Eurofins NTD
CPL	

tango-Wellsky

- Effective July 1, 2025, tango – WellSky is now the delegated manager for Wellcare's skilled home health and post-acute care benefits related to skilled nursing facilities, inpatient rehabilitation facilities, and long-term acute care hospitals. This expanded partnership aims to enhance the quality and delivery of skilled home health care and post-acute care experience for **Wellcare** members.
- Skilled Home Health Delegated Services (provided by tango):
  - Skilled nursing services on an intermittent/part-time basis – G0299 (SN) or G0300 (LPN)
  - Skilled home health aide services on an intermittent/part-time basis – G0156 (HHA)
  - Physical therapy – G0151 (PT)
  - Occupational therapy – G0152 (OT)
  - Speech-language pathology – G0153 (ST)
  - Social work – G0156 (MSW)

tango-Wellsky

- Post-Acute Care Delegated Services (Provided by Wellsky):
  - Skilled Nursing Facility (SNF):
    - Facility claims: Bill types beginning with a 2XX
    - Professional claims: Place of service codes 31
  - Inpatient Rehabilitation Facility (IRF):
    - Facility claims: Bill type of 1XX
    - Revenue code of 118, 128, 148, or 158
    - Professional claims: Place of service code 61
  - Long-term Acute Care Hospital (LTACH)
    - Facility claims: Bill type of 1XX
    - Professional claims: Place of service code 21 occurring within the date span of the LTACH stay
- To learn more about tango-Wellsky, visit the Provider Resource Center or contact them with any questions at contractmanagement@tangocare.com.

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
- **CLEARINGHOUSE CONNECTIVITY:** WellCare has partnered with Availity as our preferred EDI Clearinghouse. You may connect directly to Availity or continue to use your existing vendor/biller/clearinghouse. If you need assistance in making a connection with Availity or have any questions, please contact Availity client services at **1-800-282-4548**.

PAYER IDs

- Fee-for-Service (FFS) is defined in the Transaction Type Code BHT06 as CH, which means Chargeable, expecting adjudication.
- Encounters (ENC) is defined in the Transaction Type Code BHT06 as RP, which means Reportable only, NOT expecting adjudication.

Claim Type	FFS (CH – Chargeable) Submissions	Encounter (RF – Reporting only) Submissions
Professional or Institutional	14163	59354

FREE DIRECT DATA ENTRY (DDE)

- Availity Essentials offers providers a web portal for Direct Data Entry (DDE) claims that will submit to WellCare electronically at no cost to you. To register, submit the request to Availity's MultPayer Portal Registration.

Need EDI Support?

Companion guides for EDI billing requirements plus loop segments can be found on the Wellcare website.

For inquiries related to your electronic or paper submissions to Wellcare, please contact our EDI team at EDIBA@centene.com or Provider Services at:

- 1-855-538-0454
- 1-833-857-5715 (Access & Liberty plans)

Claims Submission Timelines

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

Wellcare
Attention Claims Department
P.O. Box 31372
Tampa, FL 33631-3372

- Participating providers must refer to their contract for timely claim submission days.
- All requests for reconsideration or claim disputes must be received within 90 calendar days of the date on the EOP.

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 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.
- To sign-up for free service for network providers visit the, Payspan website.

Coding Auditing & Editing

Wellcare 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.
- Contracted providers can submit claims payment disputes by submitting a reconsideration form within 90 calendar days from the claim determination notice.
- Submit reconsiderations or disputes to:

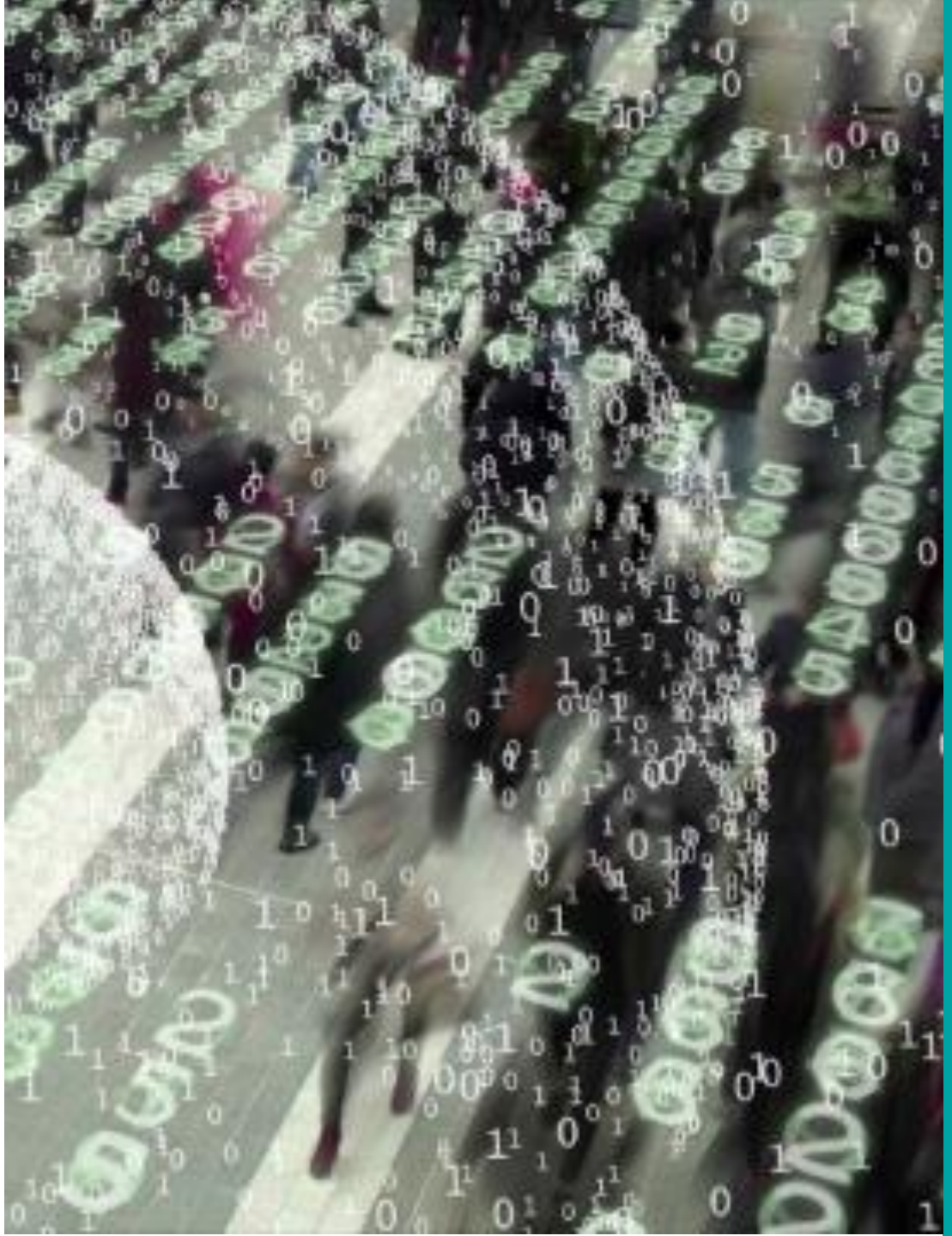
WellCare
Attn: Claim Payment Dispute
P. O. Box 31370
Tampa, FL 33631-3370
Fax: 1-877-277-1808

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 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 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
  - "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.
  - 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) 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 Medicare Outpatient Observation Notice and accompanying form instructions can be found on CMS's Beneficiary Notices Initiative (BNI).

Additional Resources for LTC & SNF Forms 3618/3619

- Texas Administrative Code
- TMHP Learning Management System (LMS) Account Login
- TMHP Long-Term Care (LTC) Program webpage
- TMHP LTC User Guide for Nursing Facility

Fraud, Waste and Abuse

Fraud, Waste and Abuse

Wellcare 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

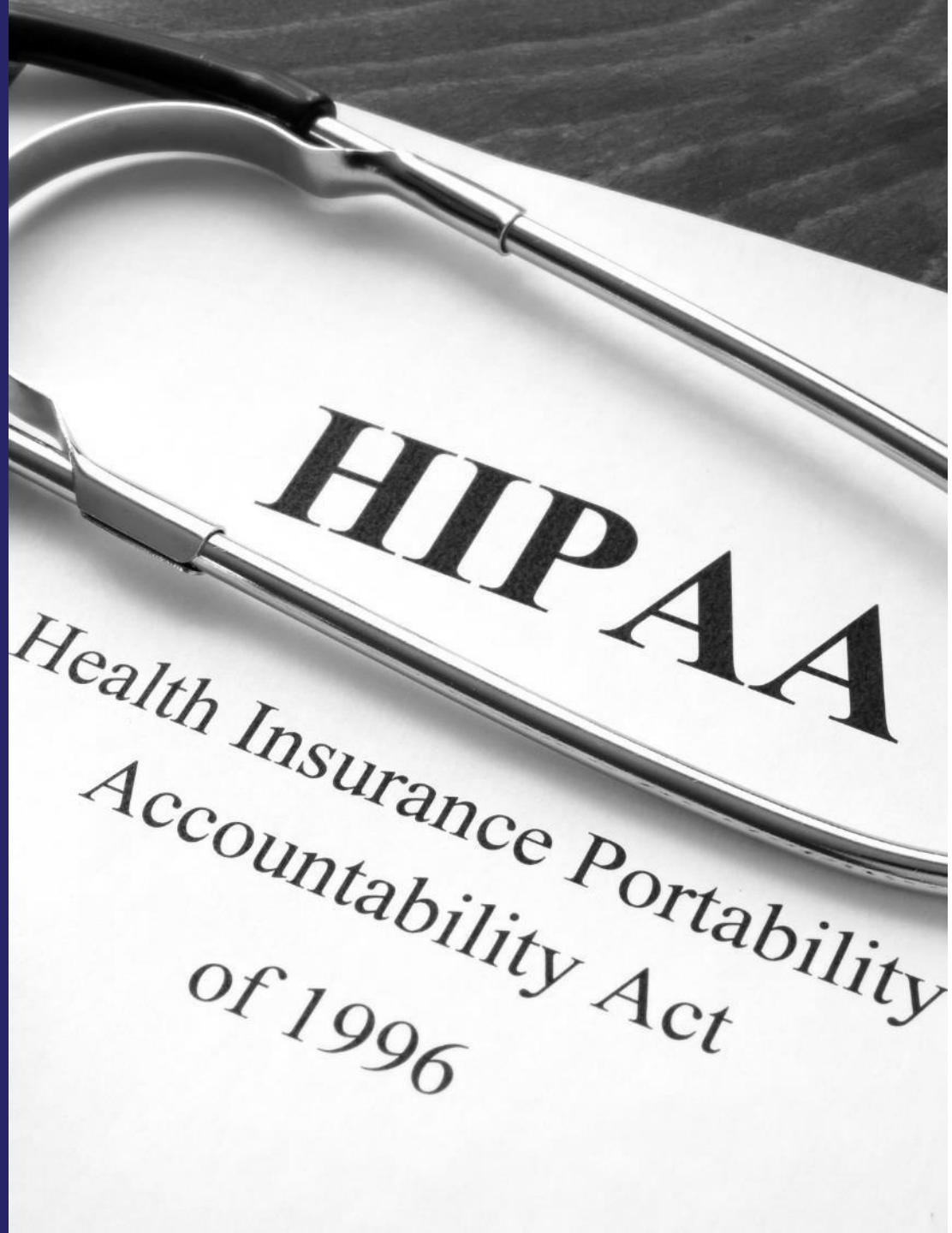
Wellcare performs front and back-end audits to ensure compliance with billing regulations. Most common errors include:

- Use of incorrect billing code
- 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

Fraud, Waste and Abuse

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 expects all of our providers, contractors, and subcontractors to comply with applicable laws and regulations including, but not limited to, 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

Fraud, Waste and Abuse

- Potential fraud, waste, or abuse reporting may be called to our anonymous and confidential hotline at 1-866-685-8664 or by making a report to the Compliance Officer on Centene's Business Ethics and Conduct Policy webpage.
- 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**
  - Fax: **1-800-223-8164**
  - NBI MEDIC: **1-877-7SafeRx** (**1-877-772-3379**)
  - Email: **HHSTips@oig.hhs.gov**
  - Medicare's **Texas** Fraud Hotline: **1-800-447-5477**
  - Visit: **HHS's Submit a Hotline Complaint**

CMS Mandatory Trainings

CMS Mandatory Trainings

All Wellcare contracted 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 and annually thereafter
- General Compliance (Compliance): Within 90 days of joining Wellcare and annually thereafter
- Fraud, Waste, and Abuse (FWA): Within 90 days of joining Wellcare 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 calendar days of execution of contract.
- Model of Care information is available on Wellcare's Annual Model of Care (MOC) Training Requirement.

Special Needs Plan Model of Care Training

wellcare

What is a Special Needs Plan (SNP)?

A SNP is a Medicare Advantage coordinated care plan (CCP) that is limited to individuals with special needs and is specifically designed to provide targeted care to plan members.

What are the Different Types of SNPs?

- ✓ **Dual Special Needs Plan (D-SNP)** – Members who are eligible for both Medicare and Medicaid.
- ✓ **Chronic Special Needs Plan (C-SNP)** – Members with specific, severe, or disabling chronic conditions.
- ✓ **Institutional Special Needs Plan (I-SNP)** – Members who live in institutions such as nursing homes.

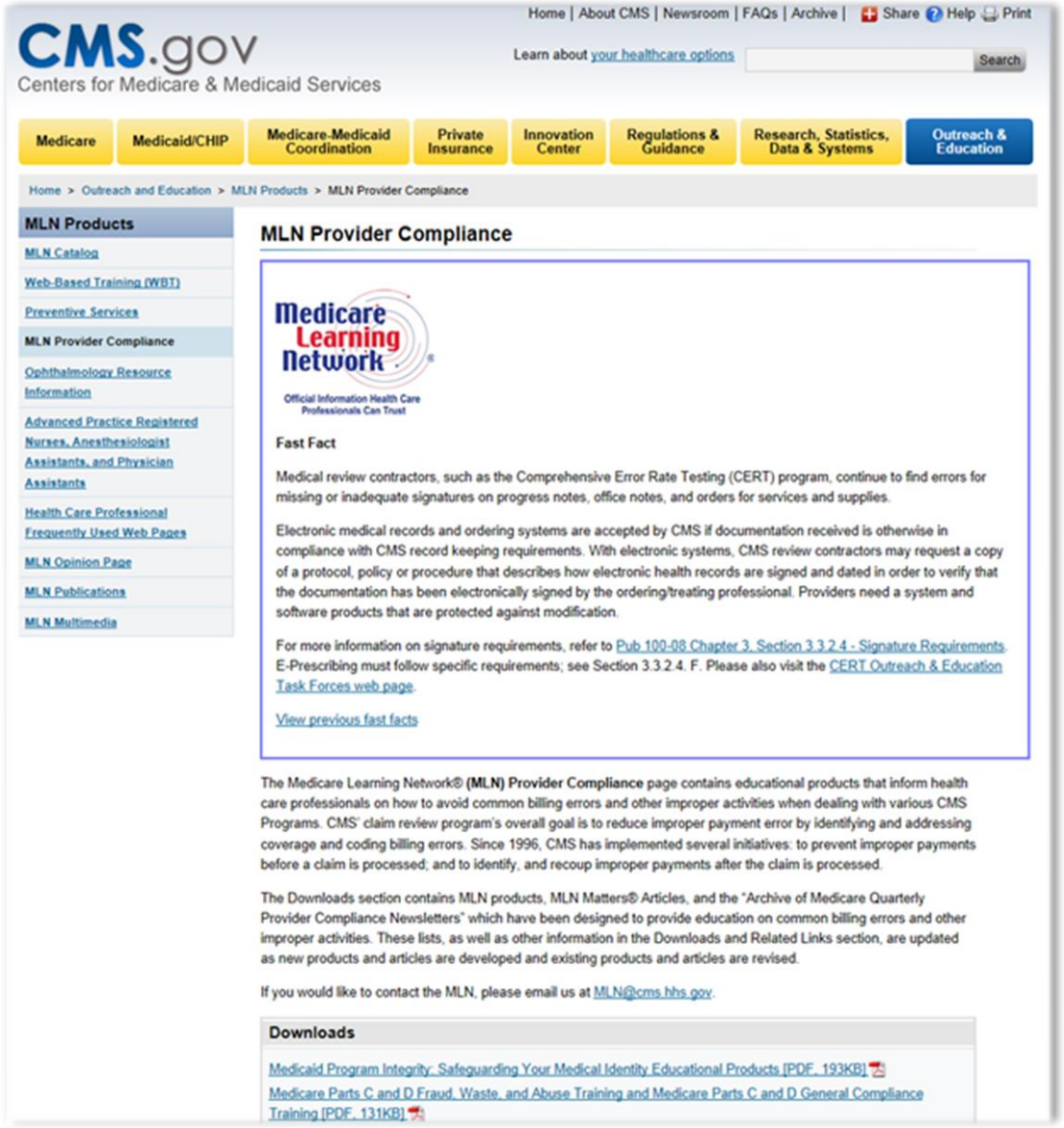
Wellcare currently offers D-SNPs and C-SNPs in multiple states across the nation.

What is a Model of Care?

As provided under section 1859(f)(7) of the Social Security Act, every SNP must have a Model of Care (MOC) approved by the National Committee for Quality Assurance (NCQA). The MOC provides the basic framework under which the SNP will meet the needs of its enrollees. The MOC is a vital quality improvement tool and integral component for ensuring that the unique needs of each enrollee are identified by the SNP and addressed through the plan's care management practices.

The MOC addresses four clinical and non-clinical elements:

- Description of the SNP population.
- Care coordination.
- The SNP provider network.
- MOC quality measurement and performance.



General Compliance & Medicare Fraud, Waste, and Abuse Training

- Providers are required to complete training via the Medicare Learning Network (MLN) website.
- Must be completed by each individual provider/practitioner within the group rather than one person representing the group collectively.
- Training must be completed within 90 days of contracting and annually thereafter.
- Complete the certificate(s) of completion or attestation through the CMS MLN and provide a copy to Wellcare.

General Compliance & Medicare Fraud, Waste, and Abuse Training

- First-Tier, Downstream, and Related Entities (FDR), as well as delegated entities, are required to complete training via the Medicare Learning Network (MLN) website.
- The trainings must be completed by each individual provider/practitioner within the group rather than one person representing the group collectively.
- The updated regulation requires all applicable entities (providers, practitioners, 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 will need to complete the certificate(s) of completion or attestation through the CMS MLN and provide a copy to Wellcare.

Questions & Answers