Ascension Complete™

Provider Orientation

2023

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
- Electronic Funds Transfer & Electronic Medical Records
- Advance Directives
- Fraud, Waste, and Abuse
- CMS Mandatory Trainings

Plan Overview

Who We Are

- Ascension Complete is a Medicare Advantage plan
- We provide quality healthcare you'd expect from a big company, but delivered on a local level
- That means our members benefit from strategic care coordination and programs through the strong and collaborative relationships we build with healthcare providers and community organizations
- Ascension Complete 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)

Who We Are

- Ascension Complete 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.
- We promote 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.

Our Products

Health Maintenance Organization (HMO)

- Medicare Health Maintenance Organization plans require members to select a PCP to coordinate their care.
- All services must be provided within the Ascension Complete network unless an emergency or urgent need for care arises, or such service is not available in-network.
- Some services require prior authorization by Ascension.

Preferred Provider Organization (PPO)

- Under a Medicare Advantage Preferred Provider Organization plan, members may use the provider of their choice, but may have higher out-of-pocket cost shares.
- Members who have selected our MA PPO plan are not required to designate a primary care physician, although it is encouraged to help coordinate their care.
- Members of our MA PPO plan may self-refer to specialty care participating providers.

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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 Ascension Complete.

- 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: AscensionComplete.com
  - 24/7 Interactive Voice Response Line - 1-833-623-0771
  - Provider Services – 1-833-623-0771
  - TTY - 711

Member Selection or Assignment of PCP

- Ascension Complete gives members the freedom to select the healthcare provider of their choice.
- Services from in-network providers are covered in based on contracted provisions, fee schedule, and any standard coding and claim guidelines, with exception of member cost sharing or co-pays, or until the maximum out-of-pocket is met.
- Additional details are determined by product:
  - **Health Maintenance Organization (HMO)**
    - HMO members are required to select a primary care physician (PCP) to coordinate their care.
    - Out-of-network care is covered only in an emergency.
    - HMO Members are generally responsible for the full cost of care received from out-of-network providers.
  - **Preferred Provider Organization (PPO)**
    - PPO members are not required to select a primary care physician.
    - These members may use the provider of their choice, regardless of whether the provider participates in the PPO network.

Membership ID Cards

Reward:

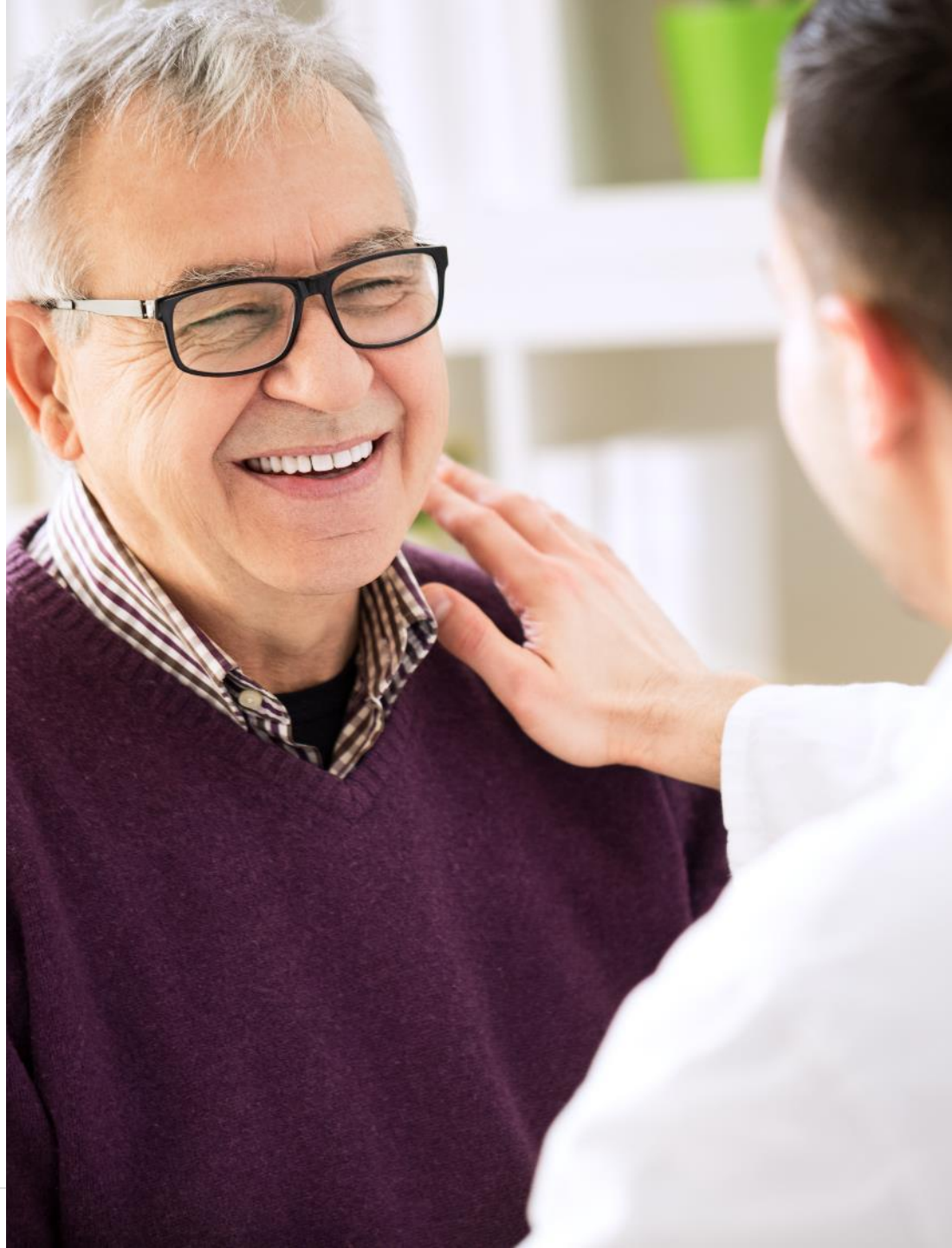
Secure:

NOTE: *Presentation of a member ID card is not a guarantee of eligibility. Providers must always verify eligibility on the same day services are rendered.*

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 on Tier 1 and 6
  - And more!



Pharmacy Formulary

- The Advantage formulary is available at AscensionComplete.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 completed form can be faxed to Pharmacy Services 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 & 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

- One routine hearing test per calendar year
- One hearing aid evaluation per calendar year

DENTAL SERVICES

- Ascension Complete offers coverage for several dental procedures, including preventive services at low or no copayment

- Not available on all benefit plans

Additional Benefits

VISION SERVICES

- One routine eye exam every year
- One pair of glasses or contacts lenses every year

OVER-THE-COUNTER ITEMS

- Commonly used over-the-counter items listing available at AscensionComplete.com, under member service
- Conveniently shipped to member's home directly
- Call to check plan and to place an order 1-866-528-4679 to order
- www.cvs.com/otchs/ascensioncomplete

- *Not available on all benefit plans

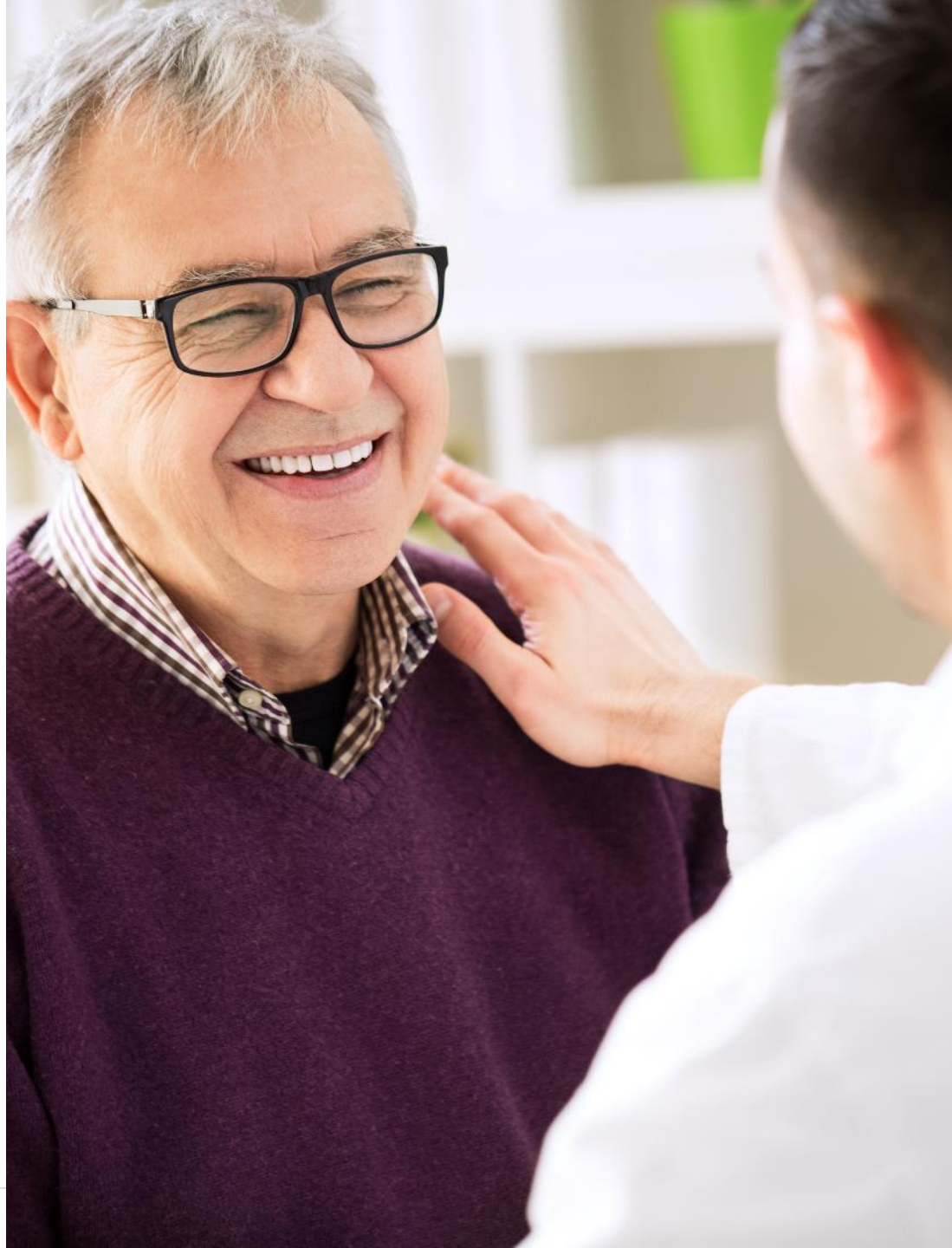
Additional Benefits

NURSEWISE

- Free health information line staffed with registered nurses 24/7 to answer health questions 1-877-236-0230

CERTIFIED FITNESS PROGRAM

- Fitness benefits provided by Silver & Fit



Additional Services

MULTI-LANGUAGE INTERPRETER SERVICES

- Interpreter services are available at no cost to Allwell members and providers without unreasonable delay at all medical points of contact
- To get an interpreter, call us at 1-833-623-0771

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 1-833-623-0771 to schedule non-emergency transportation

Providers and Authorization

Primary Care Physicians (PCP)

- 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 member 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 Web Portal at AscensionComplete.com.

Service Type	Time Frame
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	Notification requested within one business day

Prior Authorizations

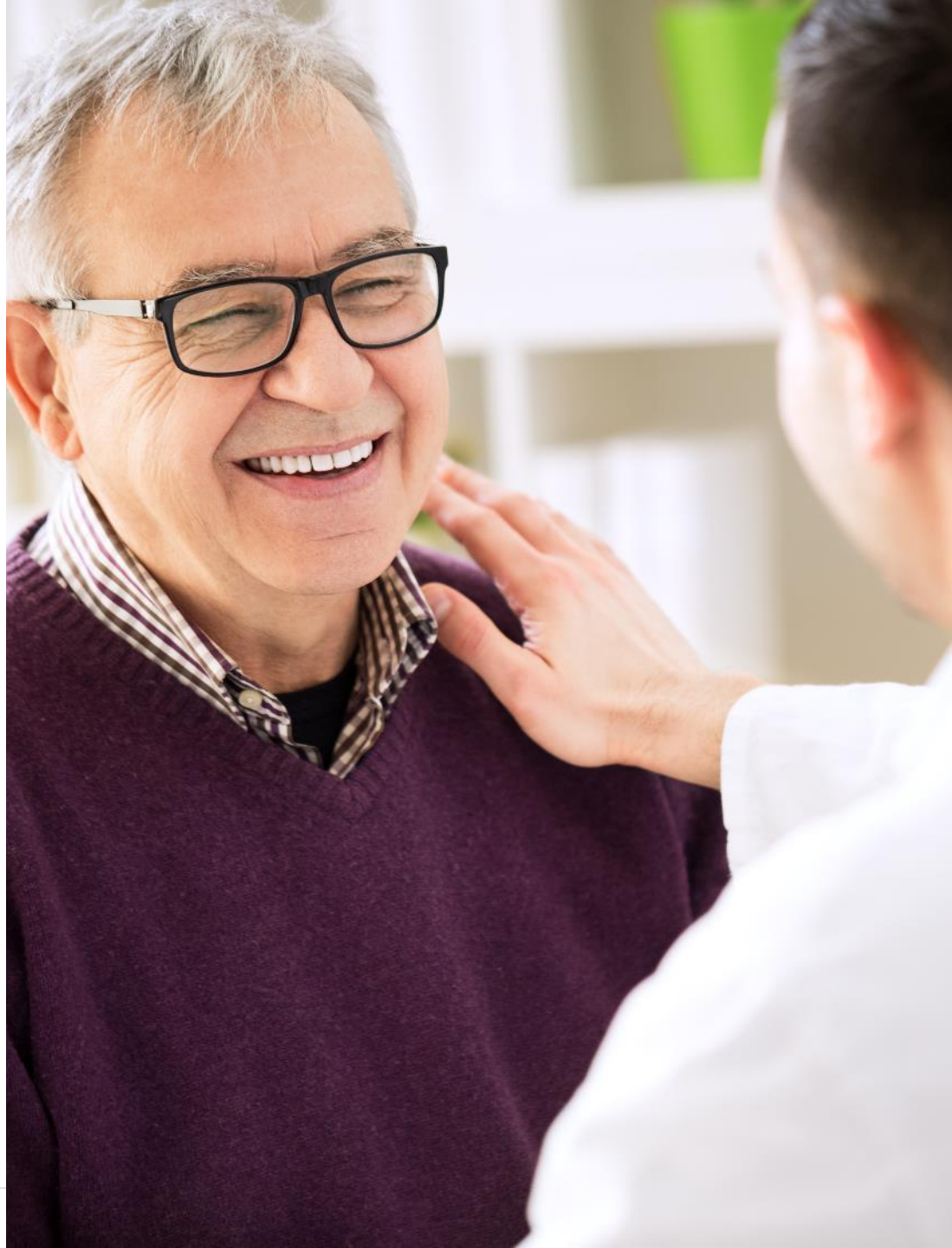
Prior authorization is required for:

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

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 out-of-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

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Preventative Care and 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

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 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 health care 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, www.medicare.gov, 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

Medicare STAR Ratings

CMS's Star Rating Program is based on measures in 9 different domains:

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 patients and document interventions regarding topics such as fall prevention, bladder control, and the importance of physical activity and emotional health and wellbeing (HOS)
- Create office practices to identify noncompliant patients at the time of their appointment
- Follow up with patients regarding their test results (CAHPS)
- 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
- 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)

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Web-Based Tools

AscensionComplete.com

Public Provider Website

Through provider page on the Ascension Complete website, providers can access:

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

EXPLORE NOW:

AscensionComplete.com

Secure Provider Portal

Easily access the data and tools you need via our secure provider portal at AscensionComplete.com

- Authorizations
- Claims
- Download Payments History
- Processing Status
- Submission / Adjustments
- Clear Claim Connection – Claim Auditing Software
- Health Records
- Care Gaps*
- Monthly PCP Cost Reports*
- Patient Listings* & Member Eligibility

**Available for PCP's only*

Updating Your Data

Providers can improve member access to care by ensuring that their data is current in our provider directory.

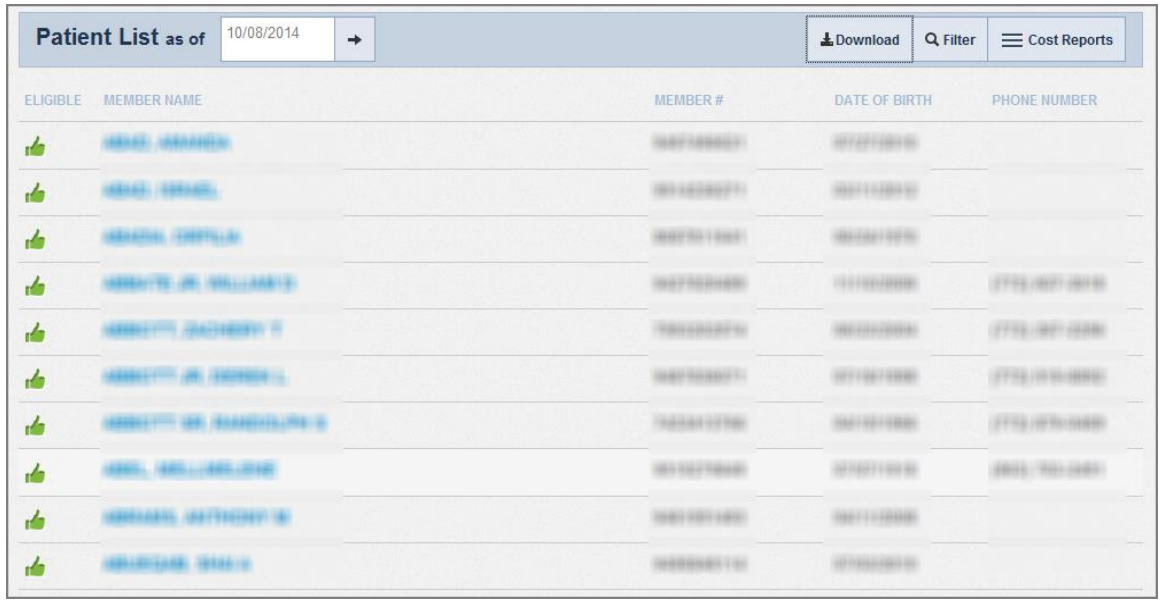
To update your provider data:

- Login to the Secure Provider Portal at **www.ascensioncomplete.com**
- From the main tool bar, select “Account Details”
- Select the provider whose data you want to update
- Choose the appropriate service location
- Make appropriate edits and click “Save”

Primary Care Provider Reports

PATIENT LIST

- Located on the Secure Provider Portal at www.ascensioncomplete.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



Network Partners

Partners and Vendors

Service	Specialty Company/Vendor	Contact Information
High Tech Imaging Services	National Imaging Associates	1-800-424-5357 www.radmd.com
Vision Services	Envolve Vision	1-833-910-0117 www.envolvevision.com
Dental Services	Envolve Dental	1-833-910-0017 www.envolvedental.com
Pharmacy Services	Centene Pharmacy Services	1-866-399-0928 (Phone) 1-866-399-0929 (Fax)

Lab & DME Partners

Lab	
Bio Reference	Diatherix Laboratories, LLC
Sequenome Center	Ambry Genetics Corp.
MD Labs	Natera, Inc.
Lab Corp	Myriad Genetic Laboratories
Quest	Eurofins NTD
CPL	Exact Sciences
Accu Reference	Genomic Health
Biodesix	

DME	
180 Medical	J&B Medical
ABC Medical	KCI
Medline	Lincare
Apria Healthcare	Hanger Prosthetics and Orthotics
Breg	National Seating & Mobility
CCS Medical	Numotion
Critical Signal Technologies	Shield Healthcare
DJO	St. Louis Medical

Specialty Pharmacy

- AcariaHealth Pharmacy
- Number 1-844-538-4661
- Accredo Health Group
- Number 1-866-718-7952
- Optum Specialty Pharmacy
- Number 1-877-546-5779
- CVS Caremark Specialty Pharmacy
- Number 1-800-238-2767
- Walgreens Specialty Pharmacy
- Number 1-888-782-8443

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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
- Ascension Complete partners with six clearinghouses for submission:
  - Availty– Payer ID Medical Claims 68069

EDI Support

Companion guides for EDI billing requirements plus loop segments can be found on the Ascension Complete website:

AscensionComplete.com

For more information about EDI, contact:

Ascension Complete

c/o Centene EDI Department

1-800-225-2573, ext. 6075525

E-mail: EDIBA@centene.com

Claims Filing Timelines

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

Ascension Complete
Attn: Claims
P.O. Box 8050
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 90 days from the original date that explanation of payment or denial is issued

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
- Free service for network providers - www.payspanhealth.com

Coding Auditing & Editing

Ascension Complete 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:

Ascension Complete
Attn: Reconsiderations
P.O. Box 8050
Farmington, MO 63640-3822

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)

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Advance Directives

Advance Medical Directives

- An advance directive will help the PCP understand the member's wishes about their health care in the event they become unable to make decisions on their own behalf. Examples include:
    - Living will
    - Health care 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 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 at: www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html

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Fraud, Waste, and Abuse

Fraud, Waste, and Abuse

Ascension Complete 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

Ascension Complete 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

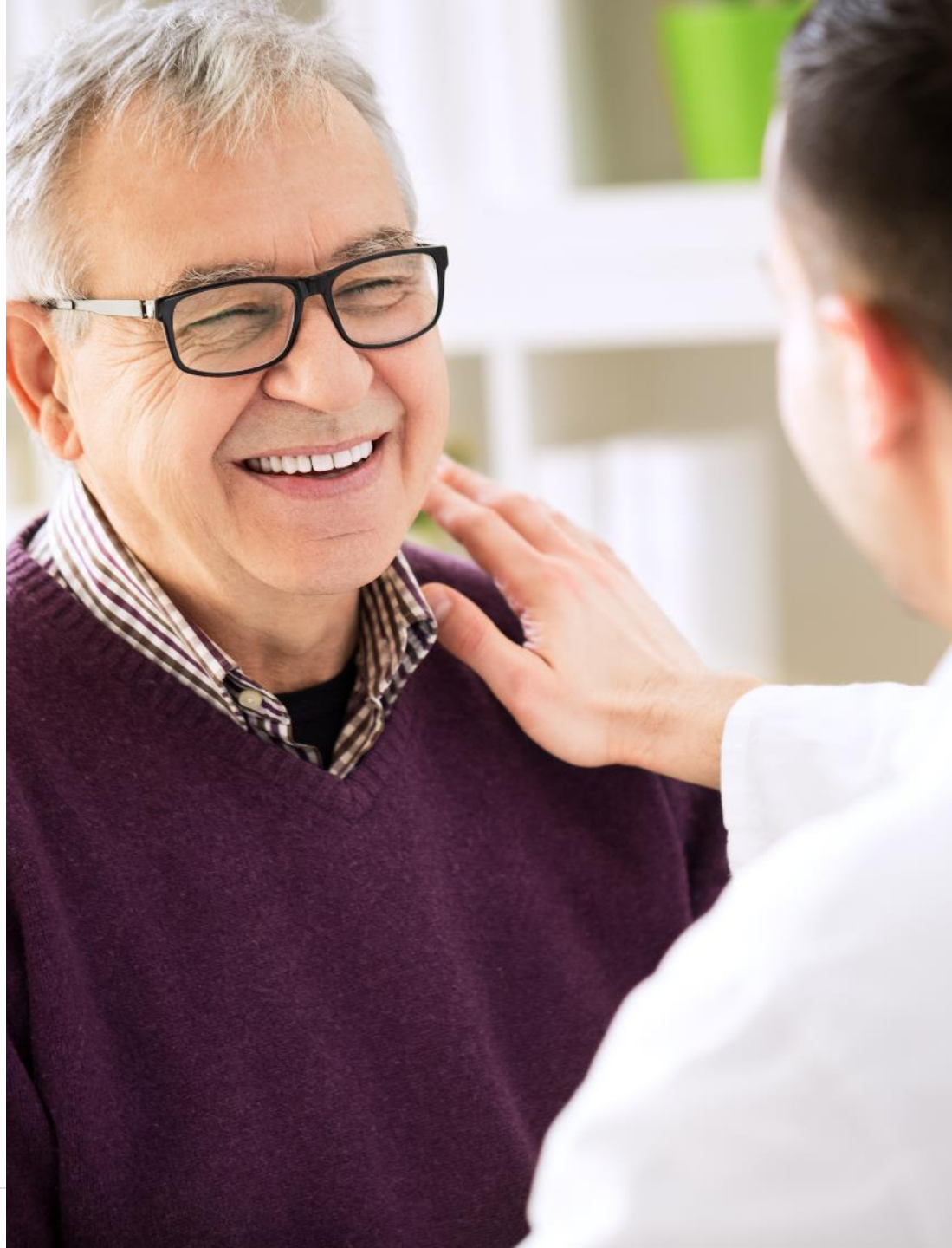
Benefits of stopping fraud, waste, and abuse:

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

Fraud, Waste and Abuse

Ascension Complete 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



Medicare Reporting

- Potential fraud, waste, or abuse reporting may be called to our anonymous and confidential hotline at 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)
  - Email: **www.OIG.HHS.gov/fraud** or **HHSTips@oig.hhs.gov**
  - Medicare's Fraud Hotline: 1-800-447-8477

CMS Mandatory Trainings

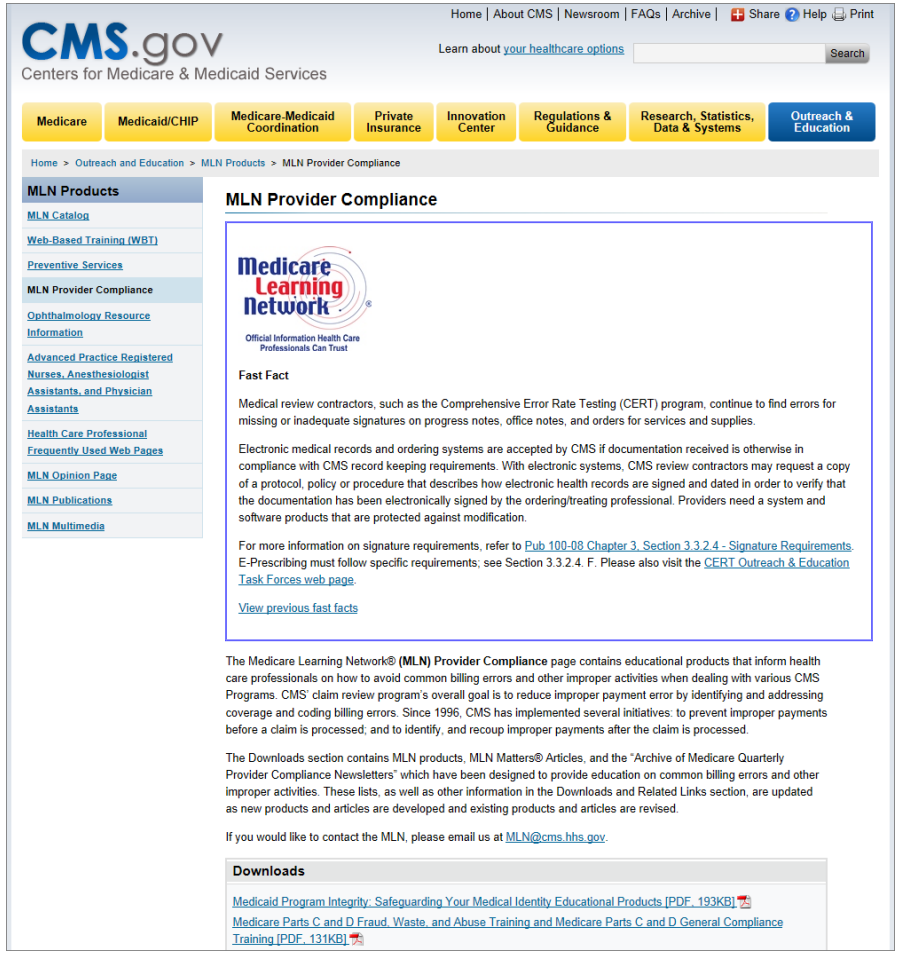
CMS Mandatory Trainings

All Ascension Complete contracted providers, contractors, and subcontractors are required to complete three required trainings:

- General Compliance (Compliance): Within 90 days of joining Ascension Complete and annually thereafter
- Fraud, Waste, and Abuse (FWA): Within 90 days of joining Ascension Complete and annually thereafter

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 Ascension Complete



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 Ascension Complete

Q & A