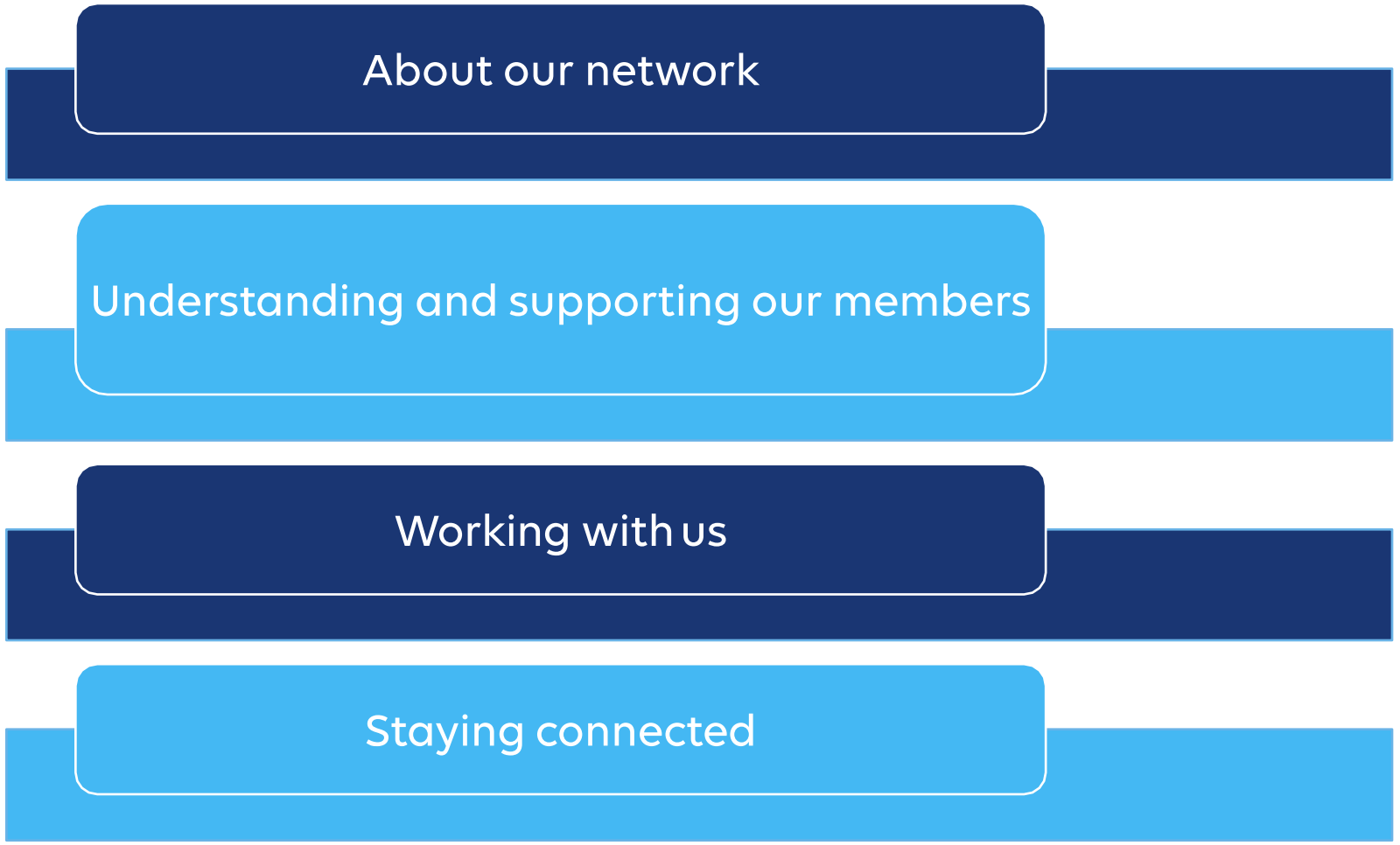
Ohio | Anthem Blue Cross and Blue Shield Medicaid | Ohio Medicaid Managed Care

Anthem provider orientation

Anthem®

Agenda


About our network
Understanding and supporting our members
Working with us
Staying connected

About our network

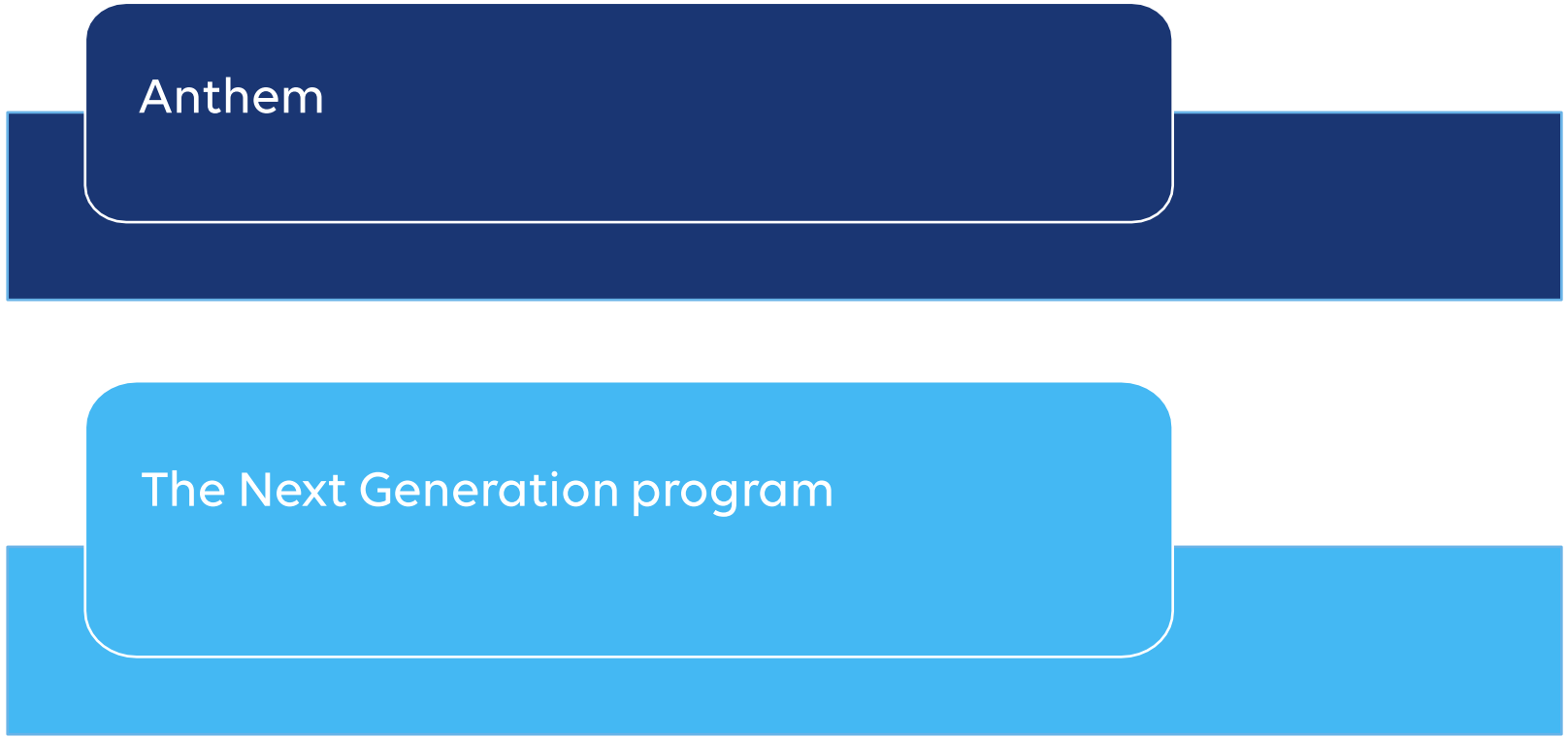
About our network

The Next Generation program

How to join our network

Partnering to win

The Next Generation program



Anthem in Ohio

- As one of the nation's leading health plans, we are already proudly served individuals in Ohio with our commercial and Medicare plans prior to February 1, 2023:
  - We now support Medicaid members in all of Ohio's 88 counties.
- The Medicaid plan aligns with the Ohio Department of Medicaid's (ODM) goals for Medicaid, putting the individual at the center of focus and improving the design, delivery, and timeliness of care coordination.

Next Generation program

ODM has successfully launched:

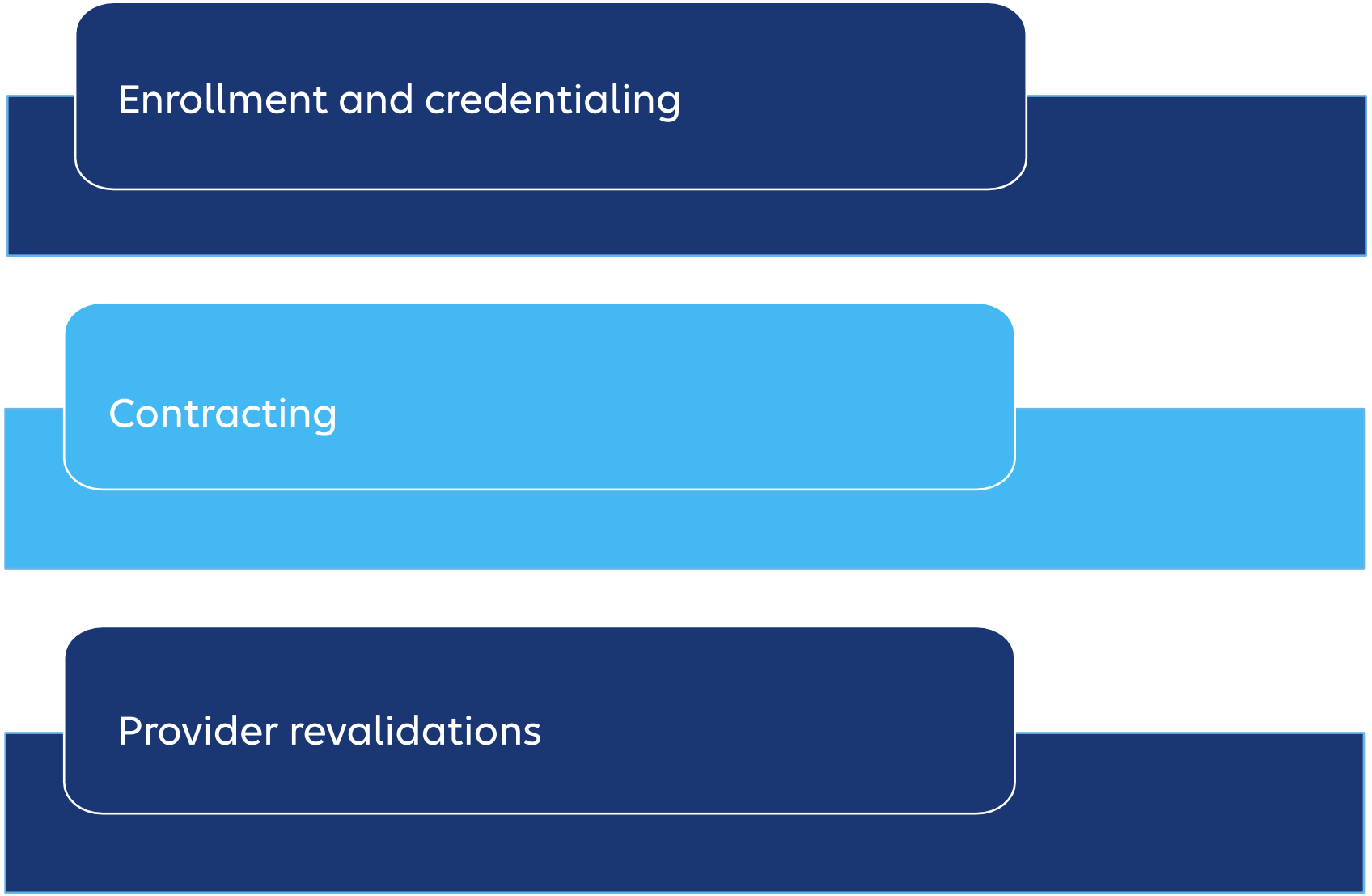
- **Ohio Resilience through Integrated Systems and Excellence (OhioRISE):** a specialized managed care program for youth with complex behavioral health and multi-system needs:
  - July 1, 2022
- **Single pharmacy benefit manager (SPBM):** an improved management and administration of pharmacy benefits for managed care recipients:
  - October 1, 2022
- **Centralized credentialing and Provider Network Management (PNM):** ODM's single, centralized provider credentialing process; allows providers to only require one credentialing and recredentialing process at the state level, versus a separate additional process done by each managed care entity (MCE) for the Medicaid line of business. Submissions for enrollment and credentialing are submitted thru the PNM:
  - October 1, 2022

Note: This does not replace the credentialing and recredentialing process for Medicare or Commercial lines of business with us.

Next Generation program (cont.)

On February 1, 2023, ODM launched the Next Generation Managed Care Plans and program requirements, including exciting improvements that support members in accessing the healthcare services and support they need. Also implemented was the new Electronic Data Interchange (EDI) increasing transparency and visibility of member care and services.

Joining our network



Enrollment and credentialing

Obtain an OHID:

- All Medicaid providers in Ohio will need an OHID, the state of Ohio's digital identity standard, to access Medicaid's new provider network management (PNM) module. To create a new OHID, visit ohid.ohio.gov/wps/portal/gov/ohid/home/home.

Enrollment and credentialing:

- As of October 1, 2022, all provider enrollment applications are submitted using Medicaid's new provider network management (PNM) module. The PNM module is the single point for providers to complete provider enrollment, centralized credentialing, and provider demographic updates:
- **To begin the credentialing process, visit ODM's Credentialing Application homepage:** tinyurl.com/mry8syj6.

Contracting

To initiate contracting visit our website, select **Our Network**, and follow the prompts for your provider type.

Providers who are already contracted with us for Medicaid in Ohio and wish to add a provider to their group should submit their information through the PNM module and check Anthem on the MCP affiliation page.

Provider revalidations

All providers are subject to either three- or five-year time-limited provider agreements. Prior to termination, letters are both mailed and emailed 120 days, 90 days, and 60 days, with a final notice at 30 days. Providers who do not submit their revalidation could experience termination at the state level, which would cascade to the Managed Care Entities (MCEs) causing claim denials as a nonparticipating provider. Emails will come from OHPNM@maximus.com.

Revalidation notices are posted in the Provider Network Management (PNM) module and can be accessed in the *correspondence* folder. Providers will also see a *begin revalidation* option in the PNM Enrollment Action Selection 120 days prior to the Medicaid Agreement end date. Providers can locate this under the *Manage Application,* then the *Enrollment Actions* option within the provider file. Select the **Revalidation/Reenrollment Quick Reference Guide** for step-by-step instructions.

Providers who need technical assistance can contact ODM's Integrated Help Desk at **800-686-1516** and follow the prompts for *Provider Enrollment* or email IHD@medicaid.ohio.gov.

Partnering to win

- OhioRISE
- Social drivers of health (SDoH)
- Telehealth
- Connections app

OhioRISE

OhioRISE is a specialized managed care program for youth with complex behavioral health and multisystem needs:

- Aetna Better Health of Ohio is the MCO for OhioRISE.
- OhioRISE members and families have the resources they need to navigate their interactions with multiple systems, such as juvenile justice, child protection, developmental disabilities, mental health and addiction, education, and others.
- Individuals enrolled in OhioRISE will keep their managed care enrollment for their physical health, and we will be included in their care management.

To be eligible for OhioRISE, an individual must:

- Be enrolled in Medicaid, either managed care or fee-for-service.
- Be under the age of 21.
- Meet a functional needs threshold for behavioral healthcare, as identified by the *Child and Adolescent Needs and Strengths* (*CANS*) assessment tool or by use of an inpatient behavioral health service.

SDoH programs — Employment services

Program overview;

- Support members from those with complex needs to skilled job seekers who are unemployed/underemployed or are looking for career exploration or educational opportunities
- Youth between the ages of 6 to 18

Strategy:

- **Employment Flex Funds** — Flexible funds to support member with employment related expenses
- **University of Cincinnati** — Coursework offered in Career Exploration or Job Search, UC instructors also provide coaching and one-on-one support
- **TutorMe** — 24/7 online tutoring platform that connects students with live tutors in over 300 subjects, including a writing lab. (Ages 6 to 18)

To make a referral:

- Employment referrals at anthemoh.findhelp.com. Enter the ZIP code and search *Anthem*. Select the *Anthem program* card to see specific program details and referral requirements. Select **Refer** or **Apply Now** and complete the screening form with referral details and contact information

SDoH-Transportation program

Standard benefit
We provide nonemergency medical transportation through Access2Care (A2C) to any member requesting transportation when the member must travel 30 miles or more from their home to receive medically necessary Medicaid-covered medical, vision, dental, and pharmacy appointments.

Value-added benefits (VABs)
To supplement the County Non-Emergency Transportation (NET) program, we provide members with 30 round trips or 60 one-way trips per calendar year for trips less than 30 miles to medical appointments and community resources such as essential shopping, grocery stores, WIC appointments, and more.

Transportation can include ambulatory sedans, vans, rideshare, bus passes and tickets, wheelchair-accessible vans, mileage reimbursement, and other appropriate modes of transportation. **Car seats and wheelchairs are not provided.**

Provider Scheduling Number: 800-304-4953
Scheduling numbers
Transportation Services Line:
- **800-282-9720** (Monday to Friday, 8 a.m. to 7 p.m. ET)
- Option 2 for Where's My Ride/Ride Assist.
  TTY 711

Member Services:
- **844-912-0938** (Monday to Friday 7 a.m. to 8 p.m. ET)
  TTY 711
- 48 hours before, up to 30 days in advance

Urgent/same day requests provided for:
- Trips to urgent care
- Hospital/facility discharge
- Chemotherapy
- Radiation
- Dialysis
- OhioRISE members

SDoH-Housing Flex Fund program

The Housing Flex Fund program is intended to prevent, divert, or resolve homelessness among our members by paying housing-related expenses:

- The program is a partnership between us and community organizations that recognize housing as a critical need in our community.
- One-time intervention to help overcome a specific need:
  - Unexpected expense
  - Health/accident-related loss of work
  - Arrears that are a barrier to exiting homelessness

Join our preferred referral network:

- To make referrals to the Housing Flex Fund program email Housingohio@anthem.com to set up a training and overview of program guidelines.
- Funds are limited; interventions must lead to permanent stable housing.

Common fund requests:

- Rental arrears
- Utility arrears
- Security deposit
- Essential move-in items
- Others as approved

Not a rental subsidy — support for a specific critical need

Telehealth

We have been providing members with telehealth services for several years.

By using telehealth, members can access service, including:

- Our Language Link Kiosk program with language line interpreter services and video conferencing behavioral health visits.
- Scheduled consultations with Ohio-licensed psychiatrists and mental health counselors.
- The substance use disorder (SUD) recovery support program.
- Remote patient monitoring (RPM) for identified members with chronic diseases including asthma, diabetes, chronic obstructive pulmonary disease, high blood pressure, and congestive heart failure.
- And much more.

Telehealth (cont.)

LiveHealth Online:

- LiveHealth Online (LHO) is a website and mobile application that gives patients 24/7 access to Ohio-licensed, board-certified physicians for urgent care consultations for clinically appropriate conditions such as cold, flu, allergies, and other nonemergent conditions anywhere and anytime via smartphone, tablet, or computer. In addition, members are also able to access scheduled consultations with Ohio-licensed psychiatrists and mental health counselors, enabling improved adherence to treatment plans.

Bright Heart Health:

- Bright Heart Health provides care for alcohol use disorder and substance use disorders and offers access to medication-assisted treatment (MAT) and other services from members' homes and primary care locations in Ohio.

Brave Health:

- Brave Health provides behavioral healthcare offering therapy, psychiatry, medication management, care management, and substance use disorder (SUD) services for members ages 16 and up.

Visit providers.anthem.com/oh for more information and additional resources.

Connections app

The Connections app: a free solution to support your OMMC members with substance use disorder (created by CHESS Health). The goal is to ensure that individuals with SUD have access to the support they need, wherever and whenever they need it — including between their appointments with you. Connections helps patients build healthy habits, reduce isolation, and celebrate achievements.

The Connections app includes:

- An existing robust virtual community with 24/7 support.
- Moderation of lively discussion groups.
- Video support meetings to create meaningful engagement.
- Trained and professional staff of certified peer recovery specialists who have lived experience with SUD and mental health.

About our network — review

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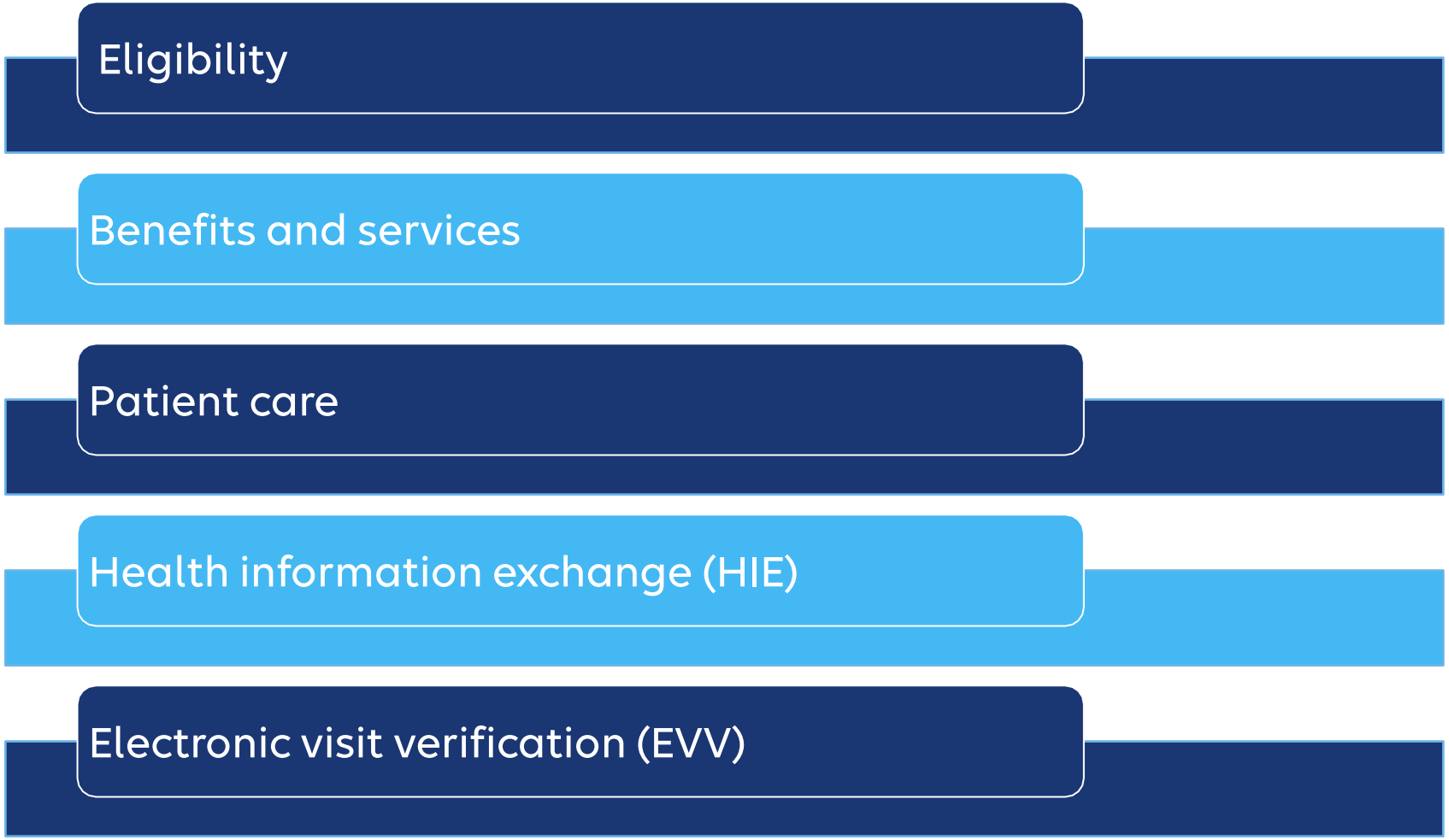
Understanding and supporting our members

Understanding and supporting our members



Eligibility

- Member ID cards
- Determining eligibility
- Choosing a PCP

Member ID cards

Individuals enrolled with us for Medicaid in Ohio have a Medicaid ID card and have access to an electronic member ID card through the Sydney app.

Note: Unlike the commercial and Medicare ID cards the Medicaid for Ohio cards do **not** have an alpha prefix before the member ID number.

Determining eligibility

Providers who have an ODM-approved established trading partner can check eligibility by:

- ODM's PNM
- Availity Essentials: https://Availity.com

Providers who do not have a relationship with an established ODM trading partner can check eligibility by:

- Availity Essentials: https://Availity.com

Choosing a PCP

Our members have the freedom to choose their most important link to quality healthcare — their doctor. We strongly encourage our members to select a PCP and remain with that provider because we believe in the positive impact of having a medical home. This home establishes a centralized hub from which all healthcare can be coordinated, no matter how many other caregivers become involved.

Members can choose or be assigned to a PCP practitioner or a PCP medical group.

Occasionally, members may encounter barriers to effective relationships with their PCP. These obstacles may arise from geographical access, cultural and language differences, or simply personal preferences. Our members may change their PCP at any time, for any reason.

Providers can access a report of their patients on the Provider Online Reporting application which can be accessed through *Payer Spaces* on Availity Essentials.

Benefits and services

Covered benefits and services

- Doula-new as of October 3, 2024
- Inpatient hospital services
- Outpatient hospital services
- Physician services
- Laboratory services
- Home health and private duty nursing services
- Hospice
- Chiropractic services
- Telehealth
- Complete list of covered services available in our *Provider Manual*

Covered benefits and services (cont.)

We do not require referrals before members can see in-network specialty physicians. Prior authorization is necessary before we will pay for services from out-of-network providers, except in cases of emergency.

Behavioral health covered services

Covered behavioral health services include, but are not limited to:

- Inpatient and outpatient behavioral/mental health services.
- Substance use disorder residential treatment.
- Outpatient substance abuse services, including intensive outpatient and partial hospital care.
- Detoxification services.
- Psychiatry services.
- Behavioral health and substance abuse counseling services.
- Assertive community treatment.
- Community psychiatric supportive treatment.
- Therapeutic behavioral services.
- Screening and brief intervention and referral to treatment.
- Opioid treatment programs.
- Mobile crisis response services.
- ***Initial*** *Child and Adolescent Needs and Strengths (CANS)* assessment.
- Transcranial Magnetic Stimulation (TMS).

Value-added services

Value-added services gives us the tools — beyond just traditional physical and behavioral care — to help the people of Ohio reach their health goals. It is about keeping members connected to their community, finding or advancing employment, learning new skills, and even getting organized financially.

All-plan link for Value-added services:

- Medicaid Consumer Hotline - Medicaid Managed Care (ohiomh.com)

Vision and dental services

Dental services

As of 1-1-25, Anthem contracts with Liberty Dental Plan for routine dental:

- Liberty Dental Plan

Vision services

Anthem contracts with EyeMed to provide covered routine vision services. We cover the following services when performed by an EyeMed-contracted provider:

- Routine vision services
- Eyeglasses
- EyeMed in Focus

Both vendors are approved ODM trading partners and claims should be submitted directly to them.

Nonemergent transportation

Nonemergent transportation is a benefit provided to our members by Access2Care. Services include transportation when the member must travel 30 miles or more from their home to receive a medically necessary Medicaid-covered service and/or pharmacy services, as well as special vehicle transportation for our members in wheelchairs:

- Routine rides must be scheduled at least two business days before the healthcare appointment.
- Same day rides can be scheduled within three hours if there is an urgent need.

We will arrange and provide transportation for members who are enrolled in OhioRISE in a manner that ensures that children, youth, and their families served by OhioRISE do not face transportation barriers to receiving services, regardless of Medicaid payer.

- Members should call **800-282-9720** to schedule rides.
- Managed Transportation (NEMT) (access2care.net)

Patient care

- Cultural competency
- Population health
- Condition Care program
- Care Management program
- Maternal child services
- Coordination of behavioral and physical health treatment
- Access and availability standards
- Healthchek

Cultural competency

We are committed to fostering cultural competency within our company and provider networks. Cultural competency can enable you to:

- Acknowledge the importance of cultural and linguistic differences.
- Recognize the cultural factors that shape personal and professional behavior.
- Enhance support of patients by incorporating cultural insights into practice.
- Strive to expand cultural knowledge.

Cultural and linguistic barriers between a provider and patient can impact:

- Communication about health needs, symptoms, and treatment planning.
- The patient's level of comfort with receiving medical care.
- Health outcomes.

We have comprehensive resources that can support you with meeting the needs of diverse patients, including cultural competency training, the Caring for Diverse Patients Toolkit, and MyDiversePatients.com.

Cultural competency (cont.)

MyDiversePatients.com features robust educational resources to help support providers.

While there's no single, easy answer to the issue of healthcare disparities, the vision of MyDiversePatients.com is to start reversing this trend one patient at a time.

On the site, you will find:

- Continuing medical education and learning experiences about disparities, potential contributing factors, and opportunities for you to enhance care.
- Real life stories about patients and the unique challenges they face.
- Tips and techniques for working with all patients to promote improved health outcomes.

Population health

Following federal and state guidelines, we have a Quality Assessment and Performance Improvement (QAPI) program in place to advance our levels of readiness, service, and care. Our approach employs a deliberate and defined, science-informed approach that is responsive to member and provider needs and incorporates systematic methods to identify reliable approaches to improving population health and reducing health disparities.

The QAPI program, aligned with Ohio's Medicaid Quality Strategy, includes the design and implementation of improvement projects in clinical and nonclinical areas that improve population health, including health equity, across all levels of care.

Population health (cont.)

Focused populations include:

- Healthy children.
- Healthy adults .
- Women and infant health.
- Children with behavioral health needs.
- Adults with behavioral health needs.
- Persons with chronic conditions (for example, asthma, diabetes, hypertension), including children with special needs and older adults.

Condition Care program

Condition Care is designed to offer holistic, member-centered care through interventions tailored to the individual's unique healthcare needs, including:

- Assessing and filling knowledge gaps to promote understanding of the disease process.
- Educating to encourage understanding of risks and complications associated with condition(s).
- Empowering members to initiate self-care and management of condition(s).
- Developing care plans, including member-centered goals to manage condition(s).
- Engaging with appropriate provider(s).
- Assisting with care coordination as needed.
- Referring to community-based programs to close SDoH needs.

Condition Care program (cont.)

Condition Care is featured on our provider website to give at-a-glace information about our program, the conditions we manage, and how to refer.

We encourage you to refer patients with any of the following conditions who could benefit from additional support: asthma, bipolar, CAD, CHF, COPD, diabetes, HIV/AIDS, hypertension, major depressive disorder (adults, children, and adolescents), schizophrenia, and substance use disorder.

To reach our team directly:

- Email: Condition-Care-Provider-Referrals@anthem.com
- Phone: **888-830-4300**

Care Management program

Our Care Management program is a collaborative effort that assists both providers and members. The program is designed to educate and assist members to become empowered, exercise their options to access the appropriate services, and optimize their healthcare benefits to meet their individual health needs. Services include:

- Short-term assistance to meet care gaps.
- Long-term, intensive, and holistic care management for our members with the most intense needs.

Providers are encouraged to engage and direct development and provide feedback on our members' care plans:

- Care Management phone: **844-441-1505**
- Care Management fax: **877-881-1831**

ODM's NurtureOhio program

We encourage providers to complete the state's *Pregnancy Risk Assessment Form* (*PRAF*), which can be completed via NurtureOhio or via fax. For detailed instructions, please visit the ODM website at medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/special-programs-and-initiatives/praf/praf.

For non-OB providers who need to notify us of a pregnancy, please use the *Report of Pregnancy (ROP) Form*, also found at the above website.

The *PRAF 2.0 Provider User Manual* can assist you in setting up access for your staff and assigning the prenatal visit role needed to access the *PRAF 2.0*.

Notification of pregnancy

We also encourage providers to complete the maternity form located in Availity Essentials:

- Perform an eligibility and benefits (E&B) request on the desired member.
- Choose one of the following benefit service types: maternity, obstetrical, gynecological, or obstetrical/gynecological.
- Before the benefit results screen, you will be asked if the member is pregnant. Select **Yes**, if applicable. If you indicate **Yes**, you may provide the estimated due date, if it is known, or leave it blank if the due date is unknown.
- After submitting your answer, the E&B will display. If the member was identified as pregnant, a maternity form will now be available. You may access the form by navigating to the Applications tab and selecting the Maternity link.
- The Availity Essentials maternity form does **not replace** the need to enter a PRAF on a pregnant member.

We require notification of delivery following birth. Birth notifications can be submitted via Availity Essentials or by fax at **877-643-0671**.

Maternal child services — New Baby, New Life

When it comes to our pregnant members, we are committed to keeping both mom and baby healthy. That's why we encourage all our moms-to-be to take part in **New Baby, New Life**SM, a comprehensive case management and care coordination program offering:

- Individualized, one-on-one case management support for women at the highest risk.
- Care coordination for moms who may need a little extra support.
- Educational materials and information on community resources.
- Incentives to keep up with prenatal and postpartum check-ups and well-child visits after the baby is born.

Our case managers are here to help you. If you have a member in your care that would benefit from care management, call us at the case manager phone number **844-441-1505**. Members can also call our 24/7 NurseLine at **844-430-0341**.

Neonatal Intensive Care Unit (NICU) Care Management program

For parents with infants admitted to the neonatal intensive care unit (NICU), we offer the NICU Care Management program. Parents/caregivers are provided with education and resources that outline successful strategies they may use to collaborate with the baby's NICU care team while inpatient and manage their baby's health after discharge.

The stress of having an infant in the NICU may result in post-traumatic stress disorder (PTSD) symptoms for parents and loved ones. To reduce the impact of PTSD among our members, we assist by:

- Guiding parent(s) into hospital-based support programs, if available.
- Screening parent(s) for PTSD approximately one month after their baby's date of birth.
- Referring parent(s) to behavioral health program resources, if indicated.
- Reconnecting with a one-month follow-up call to assess if the parent(s) received benefit from initial contact and PTSD awareness.

If you have a member in your care that would benefit from NICU Care Management, call us at CM phone **844-441-1505**. Members can also call our 24/7 NurseLine at **844-430-0341.**

Coordination of behavioral health and physical health treatment

We facilitate integrated physical and behavioral health services as a vital part of healthcare.

Our mission is to address the physical and behavioral healthcare of members by offering a wide range of targeted interventions, education, and enhanced access to care and resources that ensure improved outcomes and quality of life for members.

Care coordination qualification:

- Our case management programs use care managers for clinical case management and support for members for both physical and behavioral health.
- They also use outreach specialists for nonclinical decision management and support. These roles have been adapted for the OMMC program to care manager, care manager+, care guide, and care guide+.

Screening, brief intervention, and referral to treatment (SBIRT)

SBIRT is a comprehensive, integrated public health approach to the delivery of early intervention and screening for individuals with risky alcohol and drug use. For patients at high risk of developing a SUD or who are already dependent on substances, SBIRT helps to get them more intensive substance use treatment quickly.

The Substance Abuse and Mental Health Services Administration describes a SBIRT visit as:

- Brief (typically about 5 to 10 minutes for brief intervention and 5 to 12 minutes for brief treatment).
- Universal.
- Targeting one or more behaviors regarding risky alcohol and drug use.
- Delivered in a public health, nonsubstance abuse treatment setting.
- Comprehensive — comprising screening and referral.
- Involving research, evaluation, and collection of experiential evidence to assess the model's effectiveness.

Access and availability standards

Type of visit	Minimum standard
Emergency service	24 hours, seven days/week
Urgent care (includes medical, behavioral health, and dental services)	24 hours, seven days/week within 48 hours of request
Behavioral health nonlife-threatening emergency	Within six hours
Behavioral health routine care	Within 10 business days or 14 calendar days, whichever is earlier
CANS initial assessment	Within 72 hours of identification
American Society of Addiction Medicine (ASAM) residential/inpatient services — 3: 3.1, 3.5, 3.7	Within 48 hours of request
ASAM medically managed intensive inpatient services — 4	24 hours, seven days/week
Primary care appointment	Within 10 business days
Nonurgent sick primary care	Within three calendar days

Access and availability standards (cont.)

Type of visit	Minimum standard
Prenatal care — first or second trimester	First appointment. Within seven calendar days; follow-up appointments no more than 14 calendar days after request
Prenatal care — third trimester or high-risk pregnancy	Within three calendar days
Specialty care appointment	Within six weeks
Dental appointment	Within six weeks of request

Access and availability standards (cont.)

Services for members under 21 years of age:

- We strongly recommends our members see their PCP as soon as possible after enrollment.

Nature of visit	Appointment standards
Initial health assessments	Newborns: within 14 days of enrollment Children: within 60 days of enrollment Adults (18 to 21): within 90 days of enrollment
Preventive care visits	According to the Bright Futures/American Academy of Pediatrics (AAP) Periodicity Schedule, found within the preventive health guidelines

Services for members 21 years of age and older:

Nature of visit	Appointment standards
Initial health assessments	Within 90 days of enrollment
Preventive care visits after initial diagnosis	Within 60 days of request

Access and availability standards (cont.)

Nondiscrimination and office hours

Providers must post a statement in their offices detailing hours of operation. These hours of operation must not discriminate against our members enrolled in Medicaid. The statement must include the following:

- Waiting times for appointments.
- Waiting times for care at facilities.
- Languages spoken.

Healthchek — Early Periodic Screening Diagnosis Treatment (EPSDT) services

Healthchek is Ohio's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. It is a service package for babies, kids, and young adults younger than age 21 who are enrolled with Medicaid. The purpose of Healthchek is to discover and treat health problems early. If a potential health problem is found, further diagnosis and treatment are covered by Medicaid. Requirements include periodic screening, vision, dental, and hearing services.

Services include:

- Screening.
- Diagnosis and treatment.
- Transportation and scheduling assistance.

Healthchek — EPSDT services (cont.)

Screenings include:

- Comprehensive health and developmental assessment and history (both physical and mental health development).
- Immunizations appropriate to age and health history.
- Comprehensive, unclothed physical exam.
- Appropriate immunizations.
- Laboratory tests.
- Lead toxicity screening.
- Health education, including anticipatory guidance.
- Vision services.
- Dental services.
- Hearing services.
- Use of ODM-developed standardized developmental screening tools to assess health risks, developmental risks and progress, emotional/behavioral issues, and smoking and/or drug and alcohol problems.
- Other necessary healthcare, such as diagnostic services and treatment to correct or ameliorate defects, physical and mental illnesses, and conditions discovered by the screening services.

Healthchek — EPSDT services (cont.)

Members under the age of 21 should receive screening examinations as indicated by the *Recommendations for Preventive Pediatric Health Care*, published by Bright Futures/American Academy of Pediatrics.

Based on our claims data, we send PCPs a list of members who have not received well-child services according to our schedule. We list the specific service each member needs in the report. We also mail information to these members, encouraging them to contact their PCP to set up appointments for needed services.

You must render the services on or after the due date in accordance with federal EPSDT and NCDHHS guidelines.

We review all EPSDT requests for services covered in *42 U.S.C. § 1396d (r), and 42 C.F.R. § 441.50-62, utilizing Medical Necessity Criteria*. Such services and items, if approved through prior authorization, include those services and items listed at *42 USC 1396d (a)*, in excess of state Medicaid plan limits applicable to adults.

Healthchek and pregnancy-related services

We are committed to ensuring members receive EPSDT/Healthchek services.

We deliver Healthchek information to members at the following intervals:

- When the member is 9 months old
- When the member is 18 months old
- When the member is 30 months old
- In January of each calendar year for all members under the age of 21
- In July of each calendar year for members from age 4 to under 21
- When the member is identified as pregnant, regardless of the member's age

We encourage providers to deliver EPSDT services in school-based settings to improve access for children.

Additional partners and processes

- Integration and data flow for pharmacy (SPBM)
- EVV
- HIE

Integration and data flow for pharmacy (SPBM)

The SPBM is a pharmacy benefit manager that provides pharmacy benefits for the entire Medicaid Managed Care Population.

The SPBM works with pharmacies to ensure member access to medications, supporting ODM's goals of providing:

- More pharmacy choices.
- Fewer out-of-network restrictions.
- Consistent pharmacy benefits for all managed care members.

SPBM reduces provider and prescriber administrative burden by utilizing a single set of clinical policies and prior authorization procedures, as well as a single pharmacy program point of contact for all members.

Electronic Visit Verification (EVV)

EVV is used by caregivers for some home- and community-based services to document the time services begin and end. The codes for the services include:

Codes	
G0156	T1001
G0299	G0151
G0300	G0152
T1000	G0153

ODM provides an EVV system at no cost to all providers. Agency providers may choose to use an alternate EVV system.

For more information and resources on ODM's EVV system, visit medicaid.ohio.gov/resources-for-providers/special-programs-and-initiatives/electronic-visit-verification.

Health Information Exchange (HIE)

There are many healthcare delivery scenarios driving the technology behind the different forms of HIE available today — Health information exchange allows healthcare professionals and patients to appropriately access and securely share a patient's medical information electronically.

We will require all our Medicaid network hospitals to provide admission, discharge, and transfer (ADT) data to the HIE, thereby further expanding our access to ADT data for our Medicaid members. We will share this information with our OhioRISE and SPBM partners in real time.

Ohio HIE: CliniSync

We work closely with the HIE in Ohio to close the referral loops for SDoH.

We will offer financial incentives to encourage rural and under-served providers within the state to adopt electronic health records.

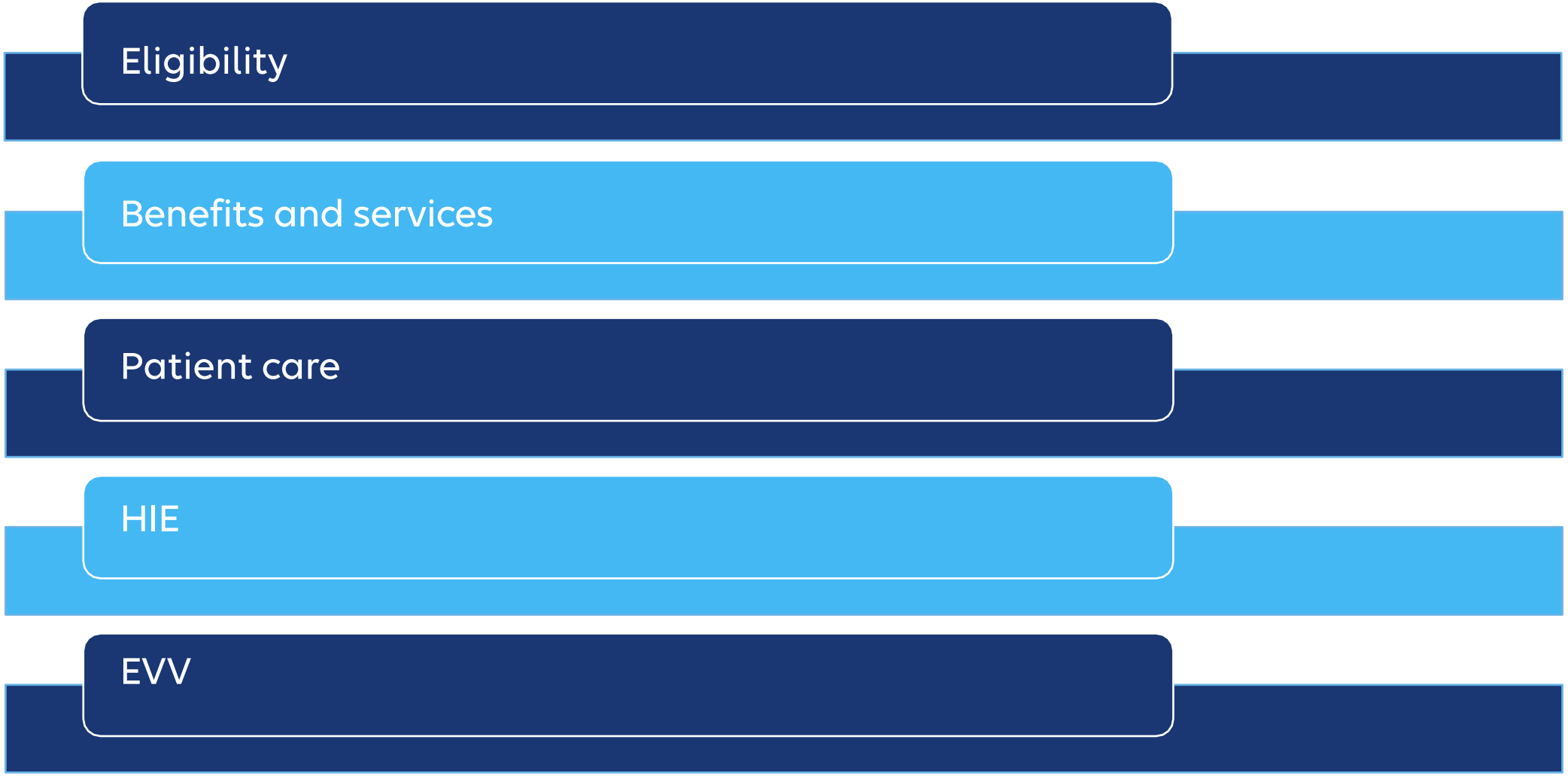
Grant dollars are available for providers in rural counties who need assistance in adopting EHR.

HIE (cont.)

We will utilize HIE data in real time to improve outcomes for providers and for our members in the following ways:

- More efficient than faxing medical records.
- Less administrative burden for providers and office staff.
- All codes in your electronic medical record system will be included in the data exchange to us.
- Improved individual provider (value-based providers) and group HEDIS® scores by closing gaps in care.
- Decrease health plan's requests for medical records.
- Reduce copy service vendor utilization and requests
- Provider staff are not displaced from daily office tasks to fulfill requests.
- Trained and proficient HEDIS staff are used which reduces copy errors.
- Members are reviewed as a whole, as opposed to via provider dashboard reports.
- Other possible resources for data can be identified while researching the medical record.
    - ONC | Office of the National Coordinator for Health Information Technology

Understanding and supporting our members — review



Working with us

Working with us

- Claims and billing
- Authorizations
- Grievances and appeals
- Fighting fraud

Claims and billing

- Submitting claims
- Claim status inquiries
- Returned claims
- EDI
- EFT-ERA
- Overpayments
- Claim payment disputes and appeals
- Member copayments and balance billing

Submitting claims

Providers who have an established ODM trading partner

Submit claims and associated attachments through ODM's fiscal intermediary via an approved trading partner.

Our payer ID: 0002937

ODM TP website: medicaid.ohio.gov/resources-for-providers/billing/trading-partners/trading-partners

Providers who do not have an established ODM trading partner

Providers will enter claims via direct data entry on Availity Essentials: https://Availity.com

Registration and contact information:

- Submit an email to: EDI-TP-Comments@medicaid.ohio.gov.
- Call the Integrated Health Desk at: **800-686-1516**, option **3** (EDI)

Submitting claims (cont.)

Timely filing requirements: Filing limits are determined as follows:

- If we are the primary payer, timely filing is 365 days from the date of service or date of discharge on the claim unless stated differently in your contract.
- If the claim has third-party liability, COB or requires submission to a third party before submitting to us, timely filing is counted from the date of the explanation of payment of the other carrier:
  - Submit within 365 days from the date of service

Clean claims

Claims submitted correctly the first time are called *clean*, meaning that all required fields have been filled in and that the correct form was used for the specific type of service provided.

A claim submitted with incomplete or invalid information may be returned. Claims will be returned for incomplete or invalid information. Claims also may be returned if they are not submitted with the proper *HIPAA*-compliant code set:

- In each case, an error report will be sent to the provider, and the claim will **not** be sent through for payment. The provider and staff are responsible for working with the EDI vendor to ensure that errored out claims are corrected and resubmitted.

Note: The submission of a clean claim should not be misconstrued as being a *proper claim* for payment. Audits (pre- and postpayment) can occur by different departments, for which a repayment may be requested. Providers are advised to follow proper coding practices using the current procedural and medical policies available. Providers may be requested to produce medical record documentation supporting the claim(s) to validate payment.

Checking claim status

Providers can check claim status via the following methods:

- Submit an inquiry via EDI through their approved ODM Trading Partner.
- Checking the claim status on Availity Essentials at https://Availity.com: Select **Login** or **Register** to access the secure site. From the Availity Essentials homepage, select **Claims & Payments** > **Claims Status**.
- Watch for and confirm plan electronic reports from your vendor/clearinghouse or, if you are using Availity Essentials as your clearinghouse, view reports under *EDI Clearinghouse/Send and Receive Files* to ensure your claims have been accepted:
  - Calling Provider Services at **844-912-1226**.
  - ODM Integrated Help Desk at **800-686-1516**.

Returned claims

We will send providers a request for additional or corrected information when the claim cannot be processed due to incomplete, missing, or incorrect information.

We may also request additional information retroactively for a claim already paid

Providers with an ODM EDI approved trading partner

To submit additional or corrected information, you should send the following directly to your ODM EDI approved trading partner.

Providers without an ODM EDI approved trading partner

To submit additional or corrected information, you should send the following through Availity Essentials.

If we request additional information or a correction to a claim, a claim follow-up is needed, and you must submit a corrected claim through your ODM EDI approved trading partner or Availity Essentials within 365 days from the date of service.

EFT and ERA

EFT

Electronic claims payment through EFT is a secure and fast way to receive payment, reducing administrative processes. EFT deposits are assigned a trace number that is matched to the 835 ERA for simple payment reconciliation.

Use enrollsafe.payeehub.org to register and manage EFT account changes.

ERA (835)

The 835 eliminates the need for paper remittance reconciliation.

The ERA (835) must be registered with ODM for the Medicaid plan.

Please work with your vendor or clearinghouse to enroll your 835s with ODM.

Use the link (PDF) to submit your 835 registration to ODM.

Note: Commercial policies with us continue to be registered and managed by Availity Essentials.

Claims overpayment recovery and refund procedure

We seek recovery of all excess claim payments from the person or entity to whom the benefit check was made payable. When an overpayment is discovered, we initiate the overpayment recovery process by sending written notification.

If you are notified by us of an overpayment or discover that you have been overpaid, mail the refund check, along with a copy of the notification or other supporting documentation, to the following address:

Anthem Blue Cross and Blue Shield Medicaid
P.O. Box 933657
Atlanta GA 31193-3657

Fax: **866-920-1874**

The *Recoupment Notification Form* and the *Overpayment Refund Notification Form* are located on our provider site at providers.anthem.com/oh > Claims Forms.

Claims overpayment recovery and refund procedure (cont.)

If a payment, request for extended payment arrangement, or dispute request is not received within 30 calendar days from the date we notify a provider of an overpayment, we will process the recovery, and overpaid funds will be applied to the provider's account as a negative balance.

If you believe the overpayment notification was created in error, contact Provider Services at **844-912-1226**.

For claims reevaluation, send your correspondence to the address indicated on the overpayment notice. If we do not hear from you or receive payment within 60 days, the overpayment amount will be deducted from your future claim payments.

Claim payment — dispute and appeal process

First level — claim payment dispute:

- The initial request for an investigation into the outcome of the claim
- Most issues are resolved during this process
- If a provider is dissatisfied with the outcome of a dispute determination, the provider may submit a claim payment appeal.

Second level — claim payment appeal:

- If the dispute did not resolve the issue, a more thorough analysis will occur utilizing all applicable statutory, regulatory, contractual, and subcontract provisions; our policies and procedures; state policies; and all pertinent facts submitted from all parties.
- Submit within 12 months from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later.

Claim payment — dispute and appeal process (cont.)

The provider or the provider's authorized representative may submit a claim payment dispute or appeal in one of three ways.

Website request — Use the Provider Availity Essentials Payment Dispute Tool at https://Availity.com. Through Availity Essentials, you can upload supporting documentation and receive immediate acknowledgement of your submission.

Written request — Include any necessary supporting documentation and mail to:

Anthem Blue Cross and Blue Shield Medicaid
Provider Payment Disputes Unit
P.O. Box 62500
Virginia Beach, VA 23466-1599

Verbal request — Contact Provider Services at **844-912-1226**, Monday through Friday, from 8 a.m. to 5 p.m.
Note: If you need to include supporting documentation (for example, *EOB*, *Consent Form*, or medical records), do not use this option.

Claim payment — dispute and appeal process (cont.)

The request should include:

- Your name, address, phone number, email, and either your NPI number or TIN.
- The member's name and their ID number for Anthem.
- A list of disputed claims, including the claim number and the date(s) of service(s).
- All supporting statements and documentation.

Member copayments and balance billing

There is no cost-share for our members enrolled in Medicaid. Members may not be balanced billed by providers for Medicaid covered services. This means that providers may not collect payment from a member for covered services above the amount we pay to the provider.

A member may request a noncovered service or a covered service for which prior authorization was denied. When prior authorization of a covered service is denied, the provider must establish and demonstrate compliance before collecting payment from the member.

See the provider manual for a complete list of items needed to demonstrate compliance.

Rule 5160-1-13.1 - Medicaid recipient liability (ohio.gov)

Authorizations

- *Medical Policies*
- *Clinical Utilization Management Guidelines*
- Prior authorization lookup tool
- Prior authorization submissions
- SNF Inpatient prior authorization
- Prior authorization status
- Authorization review timelines
- Clinical reconsideration
- Peer to Peer

Medical Policies and *Clinical Utilization Management Guidelines*

The decision-making process is based on health plan and state guidelines, as well as NCQA guidelines, and reflects the most up-to-date medical management standards. Healthcare authorizations are based on the following:

- Benefit coverage.
- Established ODM-developed criteria or, in the absence of ODM-developed criteria, *MCG*, *Medical Policies*, and *Clinical Utilization Management Guidelines,* and/or CarelonRx, Inc. criteria, as applicable.
- Community standards of care.

Decisions are based on appropriateness of care and service and existence of coverage. We do not reward practitioners and other individuals conducting utilization reviews for issuing denials of coverage or care. There are no financial incentives for utilization management decision-makers that encourage decisions resulting in under-utilization.

CarelonRx, Inc. is a separate company providing utilization review services on behalf of the health plan.

Prior Authorization Lookup Tool

Precertification Lookup Tool:

- Requirements for outpatient services can be viewed via the Precertification Lookup Tool at providers.anthem.com/oh. Search by market, member product, CPT® /HCPCS code, code description, or drug name.
- Services may be listed as requiring prior authorization that may **not** be covered benefits for a particular member. Please verify benefit coverage prior to rendering services.

Prior authorization submissions

To request prior authorization providers can submit through the Interactive Care Reviewer (ICR) located within Availity Essentials or by fax.

Inpatient authorization fax numbers:

- **877-643-0671** (Physical health): concurrent reviews for inpatient and admission request for SNF/LTAC/Acute Rehab/NF
- **866-577-2184** (Behavioral health)
- **800-964-3627** (PA fax line for MPA Medicaid prior authorization): precert for elective admissions and OP surgeries

Outpatient authorization fax numbers:

- **877-643-0672** (Physical health): HHC, high dollar imaging, PT/OT/ST, PDN, DME, chiro, acupuncture
- **866-577-2183** (Behavioral health)
- **800-563-5581** (Medical injectables)
- **800-964-3627** (PA fax line for MPA Medicaid prior authorization): precert for elective admissions and OP surgery

Note: Emergency hospital admissions, post stabilization, and observation admissions do not require prior authorization. However, notification is required within 48 hours or the next business day if the member is going to be in inpatient status.

Floor to skilled nursing facility (SNF) inpatient prior authorization process

We require the documentation of *PASRR* (*Preadmission Screening and Resident Review*) form for initial and concurrent stay prior authorization requests to an in-network skilled nursing facility (SNF) for Ohio Medicaid Managed Care members.

Floor to in-network SNF inpatient prior authorization process requires that the nursing facility and provider must be in-network; member needs to have a six-click score of 18 or below (physical and occupational therapy) and the member must not have any exclusions:

- Transfer from an acute rehab facility
- Transfer from a long-term acute care hospital (LTACH) facility
- Transfer from a psychiatric/geropsychiatric hospital unit
- Member whose prior level of function (PLOF) is nonambulatory
- Member has been admitted to a hospital from a SNF or acute rehabilitation facility
- Member was denied an LTACH admission
- Member was denied a standard SNF precertification request

Floor to skilled nursing facility (SNF) inpatient prior authorization process (cont.)

Referring provider/facility or SNF is required to submit the SNF/Rehab Worksheet (PDF) and *PASRR (Preadmission Screening and Resident Review) Form* in the initial 24-hour therapy evaluation period and clinical information within three business days after the date of admission to aid in members' care coordination, discharge planning, and member management. Documentation listed is required before a final determination is made by us.

PASRR regulations (Ohio Administrative Code Rule 5160-3-14) require that all individuals seeking admission to a Medicaid-certified nursing facility, regardless of payer source, be assessed for indications of serious mental illness and/or a developmental disability unless the member meets requirements for a Hospital Exemption.

For your convenience, the *PASRR* form can be downloaded here.

If the member does not qualify for the floor to SNF prior authorization, the referring provider/facility must go through the standard precertification process.

Prior authorization status

Prior authorization is required on all elective inpatient and post-acute requests whether in-network or out-of-network. Please notify us of any emergent IP requests within 48 hours of admission. To determine if a service requires prior authorization, providers should refer to the Precertification Look Up Tool at providers.anthem.com/oh.

You can check the status of an authorization by using the Interactive Care Reviewer located within Availity Essentials.

Authorization review timeframes

Timeliness of utilization management decisions:

- For nonurgent preservice requests: 10 calendar days
- For urgent preservice requests: 48 hours
- For concurrent reviews: 0 to 72 hours

Emergency medical services:

- We do not require prior authorization for treatment of emergency medical conditions or post stabilization services. Members may remain in an Observation status for 48 hours. In the event of an emergency, members may access emergency services 24 hours a day, seven days a week. If the emergency room visit results in the member's admission to the hospital, providers must contact us within 48 hours.

Authorization review timeframes (cont.)

Emergency stabilization and post-stabilization

The emergency department's treating provider determines the services needed to stabilize the member's emergency medical condition. After the member is stabilized, the emergency department's provider must contact the member's PCP for authorization of further services. If the PCP does not respond within one hour, the necessary services will be considered authorized.

The emergency department should send a copy of the emergency room record to the PCP's office within 24 hours.

The PCP should:

- Review and file the chart in the member's permanent medical record.
- Contact the member.
- Schedule a follow-up office visit or a specialist referral, if appropriate.

Clinical Reconsideration

A clinical reconsideration process is available to providers following an adverse determination within 30 days from the initial denial.

During the reconsideration process, providers will have an opportunity to submit additional, new clinical information to substantiate medical necessity for a previously denied preservice or concurrent inpatient stay.

To submit a clinical reconsideration, please submit new clinical information and place *reconsideration* on the fax cover sheet:

- Fax to **877-643-0671** (Physical Health)
- Fax to **866-577-2184** (Behavioral Health)

Peer-to-peer consultations

Peer-to-peer consultations

Providers have up to seven calendar days after the issuance of the denial to request a peer-to-peer review.

For behavioral health, call **844-441-1506.**

For Medical Management department, call **833-308-3035.**

Within 24 hours of your request for a peer-to-peer consultation, we will acknowledge your request and offer a peer-to-peer conversation within a mutually agreed-upon time.

Grievances and appeals

- Provider grievances and appeals
- Appeal timelines
- Appeal decisions
- External medical reviews
- State fair hearing
- Provider complaints

Preservice appeals

If an authorization is denied prior to the service being rendered to the member, the provider also has the option to file an appeal directly with us, not requiring the member consent.

Provider appeals can be submitted the following ways:

- Electronically: Use ICR on Availity Essentials at https://Availity.com.
- Fax: Directly to the Appeals department at **866-587-3316**

Appeals must be submitted within 30 calendar days from initial determination if filing without member consent. If filing on behalf of a member providers have 60 calendar days from the initial determination to submit their clinical appeal, along with the member's consent.

We will issue a decision within 10 calendar days for nonurgent services and 48 hours for urgent care services.

Appeals submitted by providers without the consent of the member are not eligible for state fair hearings; however, providers may request an additional external medical review (see external medical review process).

Provider post service authorizations

If services have been rendered to the member, providers should file a **claim payment dispute** so a medical necessity review will be completed. Providers must include medical records and provide the extenuating circumstances for not submitting the prior authorization.

Disputes are to be submitted within 12 months from the date of service (DOS) or 60 calendar days from the date on the *Explanation of Payment*, whichever was later.

Should the provider disagree with the outcome of the review a clinical appeal can be submitted:

- Appeals must be submitted within 30 calendar days from initial denial. We will send written acknowledgment of the appeal to the provider within three business days of receipt.
- We will respond to appeals associated with a claim denial within 30 days.
- Providers who have exhausted appeal rights can request an external medical review. (See EMR process)

For instructions on how to file a claim payment dispute refer to the claim payment dispute slide.

To file a clinical appeal:

- Electronically: Using ICR on Availity Essentials at https://Availity.com.
- Fax: Directly to the Appeals department at **866-587-3316**

External medical review

Services that are denied for reasons other than lack of medical necessity (for example, the service is not covered by Medicaid) are not subject to external medical review.

You have the right to request an external medical review within 30 calendar days of our decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity. The external medical review is available at no cost to you.

The request for external review must be submitted to Permedion within 30 calendar days of the written notification that the internal appeals process has been exhausted. Providers must complete the *Medicaid MCE External Review Request Form* located at hmspermedion.com.

Providers need to upload the request form and all supporting documentation to Permedion's provider website located at ecenter.hmsy.com for existing users; new users will send their documentation through secured email at IMR@gainwelltechnologies.com to establish website access).

State fair hearings

A request for a state hearing is defined as a clear expression, by the individual or authorized representative, to the effect that he or she wishes to appeal a decision or wants the opportunity to present his or her case to a higher authority. The request may be either made orally or submitted written or electronically.

Members must exhaust our appeals process before requesting a state hearing.

If we fail to adhere to notice and timing requirements as set forth in *OAC* rule *5160-26-08.4*, the member is deemed to have exhausted the appeal process and may request a state hearing.

Members enrolled in the Coordinated Services Program (CSP) are not subject to this requirement and may request a state hearing without first appealing to us.

A member or a member's authorized representative may request a state hearing within 120 calendar days from the date of an adverse appeal resolution.

State fair hearings (cont.)

Continuation of benefits

We shall continue a member's benefits when all the following conditions are met:

- The member requests an appeal within 15 days of the issuance of the *Notice of Action*.
- The appeal involves the termination, suspension, or reduction of services prior to the member receiving the previously authorized services.
- The services were ordered by an authorized provider.
- The authorization period has not expired.

Provider complaints

ODM maintains a *Managed Care Entity (MCE) Complaint Form*. This can be used by any provider who has first attempted to work directly with us, but who believes they have been unsuccessful in getting an appropriate response. Before submitting a complaint, providers should check the plan's Claims Payment Systemic Errors (CPSE) report for the issue in question.

We will receive these complaints directly, in real time, from ODM and have 15 business days to respond to the provider with a resolution. Providers are encouraged to use the appeals, grievance, or arbitration processes as outlined in their individual contract with the plan.

The *Provider Complaint Form* can be found on the:

- ODM website at providercomplaints.ohiomh.com/ComplaintForm.aspx?forceredirect=true.
- Provider website at providers.anthem.com/oh.

Working with us

Understanding fraud, waste, and abuse

Examples of fraud, waste, and abuse

Reporting fraud, waste, and abuse

Understanding fraud, waste, and abuse

Fraud

Any type of intentional deception or misrepresentation made with the knowledge that the deception that could result in some unauthorized benefit to the person committing it — or any other person; the attempt itself is fraud, regardless of whether it succeeds

Waste

Includes overusing services or other practices that, directly or indirectly, result in unnecessary costs; waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused

Abuse

When healthcare providers or suppliers do not follow good medical practice, resulting in unnecessary or excessive costs, incorrect payment, misuse of codes, or services that are not medically necessary

Understanding fraud, waste, and abuse (cont.)

To help prevent fraud, waste, and abuse, providers can assist by educating members. For example, spending time with members and reviewing their records for prescription administration will help minimize drug fraud. One of the most important steps to help prevent member fraud is as simple as reviewing the member identification card. It is the first line of defense against possible fraud. Learn more at fighthealthcarefraud.com.

Note: Presentation of a member identification card does not guarantee eligibility; providers should verify a member's status by inquiring online or via telephone. Online support is available for provider inquiries on the website, and telephonic verification may be obtained through the automated Provider Inquiry Line at **844-912-1226**.

Reporting fraud, waste, and abuse

If you suspect a provider (for example, provider group, hospital, doctor, dentist, counselor, medical supply company) or any member (a person who receives benefits) has committed fraud, waste, or abuse, you have the right to report it. No individual who reports violations or suspected fraud and abuse will be retaliated against for doing so. The name of the person reporting the incident and his or her callback number will be kept in strict confidence by investigators.

You can report your concerns by:

- Visiting fighthealthcarefraud.com. At the top of the page, select **Report it** and complete the *Report Fraud, Waste, and Abuse Form*.
- Calling **866-847-8247**.

Any incident of fraud, waste, or abuse may be reported to us anonymously; however, our ability to investigate an anonymously reported matter may be handicapped by a lack of information. Hence, we encourage you to give as much information as possible. We appreciate your time in referring suspected fraud but be advised that we do not routinely update individuals who make referrals as it may potentially compromise an investigation.

Working with us — review

Staying connected

Staying connected

Information updates

Provider updates

Updating your business information

Stay in touch

Register to stay in touch and receive all provider communications and our monthly provider newsletter, *Provider News*, via email. Register now by going to providers.anthem.com/oh.

Note: *Provider News* emails will come from providercommunications@email.anthem.com.

Updating your business information

It is critical members receive accurate and current information related to provider data. Providers and facilities must document ODM's PNM, of any demographic changes including but not limited to addresses, phone numbers and office hours. All requests must be received 30 days prior to change/update. Any requests received within less than 30 days notice may be assigned a future effective date. Contractual terms may supersede the effective date request.

Notes:

- If updates are not submitted 30 days prior to the change, claims submitted for members may be the responsibility of the provider or facility.
- The PNM serves as the system of record for provider data.

Surveys

- Provider satisfaction
- Member satisfaction

Provider satisfaction surveys and administration

We may conduct provider surveys to monitor and measure provider satisfaction with our services and identify areas for improvement. Provider participation in these surveys is highly encouraged, and your feedback is very important. We inform providers of the results and plans for improvement through provider bulletins, newsletters, meetings, and training sessions.

We conduct medical record and facility site reviews to determine provider:

- Compliance with standards for providing healthcare.
- Compliance with standards for storing medical records.
- Compliance with processes that maintain safety standards and practices.
- Involvement in the continuity and coordination of member care.

Note: We perform all inspections and evaluations in such a manner as to not unduly delay work, in accordance with the *Provider Agreement*.

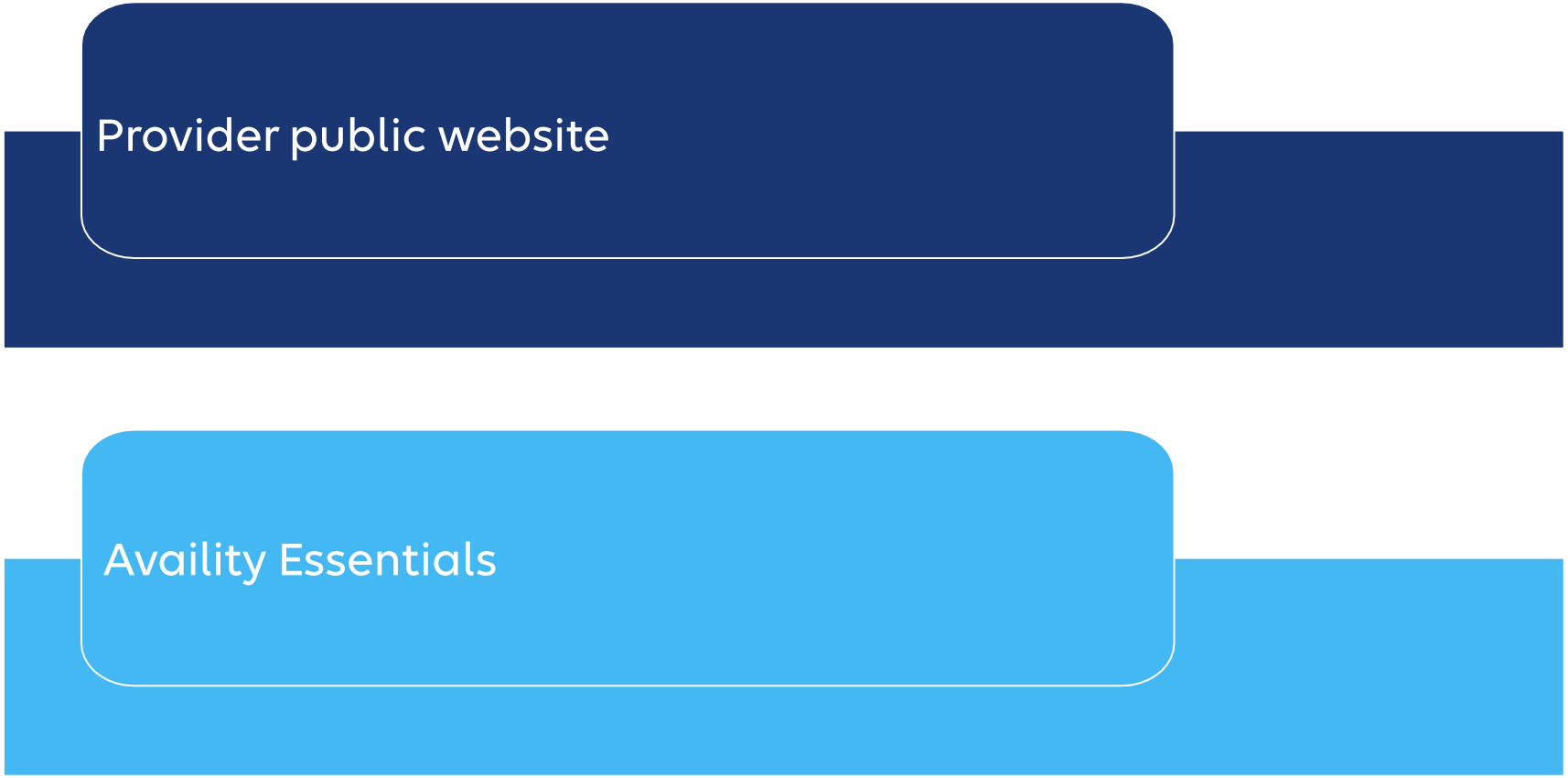
Member satisfaction surveys

Member satisfaction with our healthcare services is measured every year through theannual member satisfaction survey. An NCQA-certified vendor conducts a survey called the CAHPS®.The survey is designed to measure member satisfaction with our services,including:

- Access to care.
- Customer service.
- Provider communications.
- Provider office staff performance.

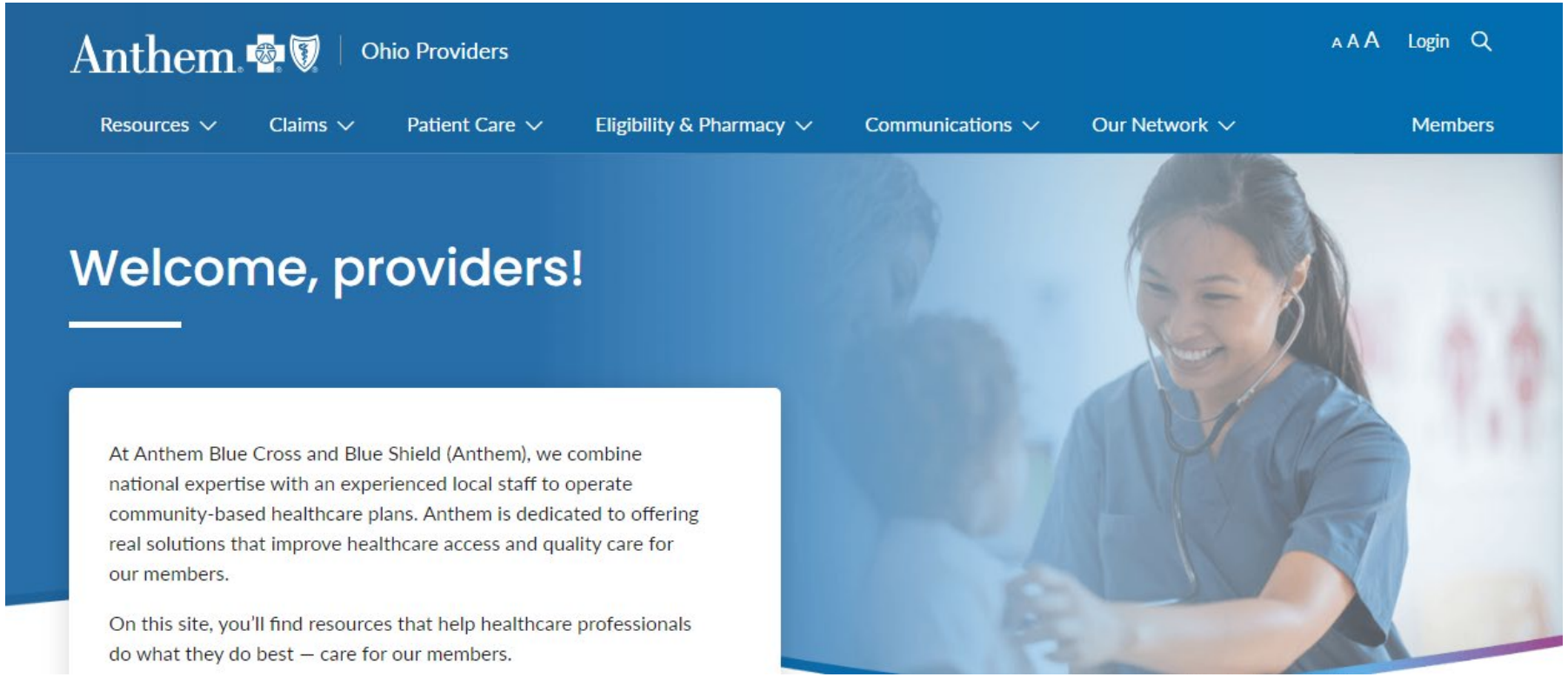
We distribute the results of the CAHPS® survey to both members and providers. Providers should review the results, share the results with office staff, and incorporate appropriate changes in their offices.

Provider websites



Provider website

The provider website is available at providers.anthem.com/ohio-provider/home.



Availity Essentials and training resources

Availity Essentials (https://Availity.com) is a web platform used by providers to securely access patient information, such as eligibility, benefits, claim status, authorizations, and other proprietary information.

Healthcare providers can use a single login to access multiple health plan providers at no cost. The registration process is easy, and multiple resources and trainings about site navigation are available.

Digital Solutions Learning Hub (on24.com) is a one-stop shop for provider training on Availity. It consolidates resources from Availity and us in an organized, easily accessible format, offering both the latest updates and foundational knowledge.

Availity Essentials/Total Member View

Total Member View (TMV) provides a full 360-degree view of patient health and treatment history.

Easily identify and provide feedback on patients missing essential preventive screenings, follow-up appointments, or necessary treatments.

User-friendly guides available for seamless navigation and usage of TMV.

The TMV user interface is purple and says *Total Member View* in the upper right corner. TMV highlights include viewing your patients who have a care gap and providing feedback on care gaps.

The *Total Member View Availity User Guide* offers step-by-step instructions on accessing and navigating through the Availity Essentials platform and how to use the system. This guide is available through the Digital Solutions Learning Hub (on24.com).

Request for additional information (RAFI)

Digital Request for Additional Information (RFAI) is the easiest way to submit attachments requested by your payer using Availity Essentials. There is no need to fax or mail paperwork to complete your claim submissions anymore; just use the digital channels provided for your organization.

The notification center is located on the top of the Availity Essentials home page. If your payer has requested documentation, there will be a message stating there are requests in your work queue. Select the hyperlink to navigate to the Attachment Dashboard and view the request.

The Attachment Dashboard is where all attachment requests are displayed. You can use the hyperlink in the notification center or navigate to **Claims & Payments** > **Attachments New**.

To locate a specific RFAI request, the request number will begin with RFAI. If you notice multiple requests in your dashboard, take advantage of the filters. You have the option to search, filter, and sort for multiple values such as tax ID, NPI, and request type.

Select **Upload Attachment** to view the type of document requested. Your uploaded requests will be visible in the History tab once accepted. Select the **Record History** icon on the right side of the request to view the Availity Transaction ID for specific Availity Essentials questions or select **Health Plan Transaction ID** if you need to contact your payer for questions.

This dashboard, located in Payer Spaces, allows your organization to understand how many digital requests have been sent, how many finalized claims there are based on your attachment submissions, and the average turnaround time from the initial payer request to the claim finalization. To view your Digital RFAI Progress Dashboard application, select **Payer Spaces** from the drop-down menu and choose your payer tile:

Training is available on the Availity Essentials website.

Provider Advisory Council

We invite providers to participate in our Provider Advisory Council. The meetings intent is to collaborate with our provider community to gather input, discuss trends, identify challenges, and remove barriers ultimately improving the healthcare delivery system.

If you are interested in participating, you may sign up by selecting Provider Advisory Council (chkmkrt.com).

Staying connected — review

Helpful resources

Quick links

Quick links

Ohio Department of Medicaid (ohio.gov)

Our provider website

Provider News | Home

Provider reference guide: claims disputes and appeals, and clinical appeals for UM decisions | *Provider News*

Prior authorization lookup tool

Provider manuals and guides

Thank you

We appreciate you taking the time to attend our training and hope the information covered today answered any of your questions.

In a world of escalating healthcare costs, we work to educate our members about the appropriate access to care and their involvement in all aspects of their healthcare.

We look forward to working with you to continue this education and provide valuable healthcare to our members — your patients.

Contact information:

- Provider website: providers.anthem.com/oh
- Provider Services: **844-912-1226**
- Please send any questions not covered in this presentation or the Frequently Asked Questions to OhioMedicaidProvider@anthem.com.

Addendum

CAHPS

What is CAHPS?

It is an annual survey to assess consumers' experience with their health plan and healthcare services. Asks your patients to rate and evaluate their experience with their:

- Personal doctor.
- Specialist they see most often.
- Health plan.
- Healthcare.

Additional resource: What Matters Most: Improving the Patient Experience (providers.anthem.com/ohio-provider/resources/training-academy/improving-the-patient-experience).
For a full CAHPS overview, visit the Provider Training Academy/Provider Education webpage.

CAHPS (cont.)

Why focus on patient experience?

There is a strong correlation between patient experience and positive healthcare outcomes.

Patients with chronic conditions demonstrate greater self-management skills and quality of life when they have a positive provider experience.

Patient retention is greater when there is a high-quality relationship with the provider.

Patient experience is reflected in online reviews; thus, it can affect your reputation.

It leads to decreased malpractice risk.

Improving patient experiences can increase employee retention.

Additional resource: What Matters Most: Improving the Patient Experience (providers.anthem.com/ohio-provider/resources/training-academy/improving-the-patient-experience)..
For a full CAHPS overview, visit the Provider Training Academy/Provider Education webpage.

CAHPS (cont.)

How could you improve the patient experience?

Here are some suggestions:

- Encourage office staff to be courteous and empathetic.
- Respect cultural differences and beliefs.
- Demonstrate active listening by asking questions and making confirmatory statements.
- Spend enough time with the patient to address all their concerns.
- Provide clear explanations of treatments and procedures.
- Verify that your patient understands their treatment plan.
- Obtain and review records from hospitals and other providers.

Additional resource: What Matters Most: Improving the Patient Experience (providers.anthem.com/ohio-provider/resources/training-academy/improving-the-patient-experience)..
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