Provider Orientation:

Allwell from MHS
(Medicare Advantage)
Agenda

- Plan Overview
- Membership, Benefits, and Additional Services
- Providers and Authorizations
- Preventive Care and Screenings
- Model of Care (For DSNP only)
- Medicare STAR Ratings
- Web Based Tools
- Network Partners
- Billing Overview
- Electronic Funds Transfer & Electronic Medical Records
- Advance Directives
- Fraud, Waste, and Abuse
- CMS Mandatory Trainings
Plan Overview
Allwell from MHS provides complete continuity of care to members including:

- Integrated coordination of care
- Care management
- Co-location of behavioral health expertise
- Integration of pharmaceutical services with the PBM
- Additional services specific to the beneficiary needs

Approach to care management facilitates the integration of:

- Community resources
- Health education
- Disease management

Promotes access to care as beneficiaries are served through a single, locally-based multidisciplinary team including:

- RNs
- Social Workers
- Pharmacy Technicians
- Behavioral Health Case Managers
2019 Counties

[Map of Indiana showing 2018 and 2019 counties with different colors]
Membership, Benefits, and Additional Services
Medicare beneficiaries have the option to stay in the original fee-for-service Medicare Plan or choose a Medicare Advantage Health Plan.

Advantage members may change PCPs at any time.

Changes take effect on the first day of the month.

Providers should verify eligibility before every visit by using one of the below options:

- Website: allwell.mhsindiana.com
- 24/7 Interactive Voice Response Line: 1-855-766-1541
- Provider Services: 1-855-766-1541
- TTY: 711
Allwell Plan Coverage

晡 We offer HMO, PPO, and HMO DSNP plans
晡 $0 for Premiums*
晡 $0/$5 PCP copay (HMO v. PPO)
晡 $0 & $5 generics
晡 Great Value-Add Benefits
  • $65 quarterly OTC benefit, $85 quarterly OTC benefit for DSNP
  • Hearing aid benefit
  • $150 eyeglasses benefit for HMO and PPO, $200 benefit for DSNP
  • Silver & Fit
  • Preventive dental
晡 All Part A and Part B benefits by Medicare
晡 Part B drugs – such as chemotherapy drugs
晡 Part D drugs – no deductible at network retail pharmacies or mail order, will have copay or coinsurance for some tiers

*$0 premiums apply to all of the HMO products; and, the PPO product in Allen, Elkhart, St. Joseph, Wells, and Whitley Counties.
Pharmacy Formulary

🎉 The Allwell formulary is available at: allwell.mhsindiana.com
  • Please note that the PPO/HMO and the DSNP formulary are different.
🎉 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 Envolve Pharmacy Solutions at: 1-800-977-8226
Covered Services

- Hospital Inpatient
- Hospital Outpatient
- Physician Services
- Prescribed Medicines
- Lab and X-Ray
- Emergent Transportation
- Home Health Services
- Screening Services
- Preventive 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

• $0 co-pay for one routine hearing test every year
• $0 co-pay for one hearing aid fitting evaluation
• Various levels of hearing aids available at copays between $0 and $995, with a 60 day evaluation period

🎉 Preventive Dental Services

• Two Oral exams per year with no co-pay
• Two Cleanings per year with no co-pay
• One Dental X-Ray per year with no co-pays
Additional Benefits

🎉 Vision Services

- One routine eye exam every year
- One pair of glasses or contacts lenses every year
- $150 eyewear allowance each year ($200 for DSNP)

🎉 Over-The-Counter Items

- Commonly used over-the-counter items – listing available at: allwell.mhsindiana.com
- Conveniently shipped to member’s home within 5 – 12 business days
- Call Member Services at 1-855-766-1541 (TTY: 711) to order items up to $65 per calendar quarter ($85/quarter for DSNP)
Additional Benefits

❖ Nurse Advice Line
  • Free nurse advice line staffed with registered nurses 24/7 to answer health questions

❖ Certified fitness program at specified Silver & Fit gyms at no extra cost or an in-home fitness kit
Additional Services

Multi-language Interpreter Services

Free interpreter services to answer questions about the medical or drug plan. To get an interpreter, call us at 1-855-766-1541.

Non-Emergency Transportation (DSNP only)

Provides 36 one-way trips per year, to approved locations

Schedule trips 48 hours in advance using the plan’s contracted providers

Contact us at 1-855-766-1541 to schedule non-emergency transportation
Providers and Authorization
Primary Care Physicians (PCP)

PCPs serve as a “medical home” and provide the following:

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

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective/scheduled admissions</td>
<td>Required five business days prior to the scheduled admit date</td>
</tr>
<tr>
<td>Emergent inpatient admissions</td>
<td>Notification required within one business day</td>
</tr>
<tr>
<td>Emergency room and post stabilization</td>
<td>Notification requested within one business day</td>
</tr>
</tbody>
</table>
Prior authorization is required for services such as:

- 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

Use the “Pre-Auth Needed Tool” at allwell.mhsindiana.com to check all services
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

- Please note that the Allwell PPO plan DOES include out-of-network benefits at a higher cost share to the member.
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.
- Medical Necessity Appeals must be initiated within 30 days of the denial to be considered. Please note, this is different than a claim appeal request.
- Member appeal rights will be fully explained.
Preventive Care & Screening Tests
Preventive Care

🧬 No copay for all preventive services covered under original Medicare at zero cost-sharing

🧬 Initial Preventative Physical Exam - Welcome to Medicare
  - Measurement of height, weight, body mass index, blood pressure, visual acuity screen, and other routine measurements
  - Also includes an electrocardiogram, education, and counseling
  - Does not include lab tests
  - Limited to one per lifetime

🧬 Annual Wellness Visit
  - Available to members after the member has the one-time initial preventative physical exam (Welcome to Medicare Physical)
## Preventive Care

<table>
<thead>
<tr>
<th>Preventive Care</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal Aortic Aneurysm Screening</td>
<td>Medical Nutrition Therapy Services</td>
</tr>
<tr>
<td>Alcohol Misuse Counseling</td>
<td>Medication Review</td>
</tr>
<tr>
<td>Blood Pressure Screening</td>
<td>Obesity Screening and Counseling</td>
</tr>
<tr>
<td>BMI, Functional Status</td>
<td>Pain Assessment</td>
</tr>
<tr>
<td>Bone mass measurement</td>
<td>Prostate Cancer Screenings (PSA)</td>
</tr>
<tr>
<td>Breast Cancer Screening (mammogram)</td>
<td>Sexually Transmitted Infections Screening and Counseling</td>
</tr>
<tr>
<td>Cardiovascular Disease (behavioral therapy)</td>
<td>Tobacco Use Cessation Counseling (counseling for people with no sign of tobacco-related disease)</td>
</tr>
<tr>
<td>Cardiovascular Screenings</td>
<td>Vaccines, Including Flu Shots, Hepatitis B Shots, Pneumococcal Shots</td>
</tr>
</tbody>
</table>

- Colonoscopy
- Cervical and Vaginal Cancer Screenings
- Colorectal Cancer Screenings
- Depression Screening
- Diabetes Screenings
- Fecal Occult Blood Test
- Flexible Sigmoidoscopy
- HIV screening
- Hepatitis B Shots
- Pneumococcal Shots
- Flu Shots
- Vaccines
Model of Care
(DSNP Only)
The Model of Care is Allwell’s plan for delivering our integrated care management program for members with special needs.

The goals of Model of Care are:

- Improve access to medical, mental health, and social services
- Improve access to affordable care
- Improve coordination of care through an identified point of contact
- Improve transitions of care across healthcare settings and providers
- Improve access to preventive health services
- Assure appropriate utilization of services
- Assure cost-effective service delivery
- Improve beneficiary health outcomes
Model of Care (DSNP Only)

Model of Care elements are:
- Description of the SNP Population
- Care Coordination and Care Transitions Protocol
- Provider Network
- Quality Measurement
Model of Care Process (DSNP Only)

Every dual member is evaluated with a comprehensive Health Risk Assessment (HRA) within 90 days of enrollment, and at minimum annually, or more frequently with any significant change in condition or transition of care.

The HRA collects information about the member’s medical, psychosocial, cognitive and functional needs, and medical and behavioral health history.

Members are then triaged to the appropriate Allwell Case Management Program for follow up.
Allwell values our partnership with our physicians and providers.

The Model of Care requires all of us to work together to benefit our members by:

- Enhanced communication between members, physicians, providers, and Allwell
  Interdisciplinary approach to the member’s special needs
- Comprehensive coordination with all care partners
- Support for the member's preferences in the Model of Care
- Reinforcement of the member’s connection with their medical home
Medicare STAR Ratings
Medicare Star Ratings

What Are CMS Star Ratings?

 brewers 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.

 brewers The ratings are posted on the CMS consumer website, medicare.gov, to give beneficiaries help in choosing an MA and MA-PD plan offered in their area.

 brewers 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 Impact & Improve Star Ratings?

- Continue to encourage patients to obtain preventive screenings annually or as recommended
- Manage 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
- Create office practices to identify non-compliant patients at the time of their appointment
- Follow-up with patients regarding their test results
How Can Providers Impact & Improve Star Ratings?

Submit complete and correct encounters/claims with appropriate codes and properly document medical chart for all members, including availability of medical records for chart abstractions

Review the gap in care files listing members with open gaps, which is available on our secure portal

Review medication and follow up with members within 14 days post hospitalization

Identify opportunities for you or your office to have an impact on your patient’s health and well-being

Make appointments available to patients and reduce wait times
Web-Based Tools
Through the website, providers can access:

- Billing Manuals
- Forms
- HEDIS Quick Reference Guides
- Provider News
- Pre-Auth Needed Tool
- Provider Resources
Provider Website

On our health plan website providers can access:

未经授权

Authorization

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
Online Search Tools

- Determine whether a provider is in network
- Conduct Formulary look-up
- Find Summary of Benefits and EOC
Secure Provider Portal

On the secure provider portal you can access:

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

*Available for PCP’s only
Primary Care Provider Reports

.patient_list
- located on the secure portal at provider.mhsindiana.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.
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
- 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 Save
Patient Analytics
Patient Analytics

What is Patient Analytics?

Patient Analytics is a web-based patient care platform that uses claims data to create a detailed patient- and population-level reporting.

What Does Patient Analytics Do?

Within Patient Analytics, each patient has a detailed clinical profile. Patients with the most care gaps are identified allowing providers to take a proactive approach to managed care.

Key Benefits

- **Population Health**: Providers are able to manage member’s information using patient registries. The information can easily be accessed online and many elements can be printed.
- **Medical History** – Patient Analytics contains up to 24 months of medical, pharmacy, and lab claims.
- **Increased Visibility** – Primary Care Physicians (PCPs) will have access to claims history submitted by other providers.
- **Improved Outcomes**: Patient Analytics helps providers improve patient care, performance, outcomes and adherence to quality measures.
Patients Tab

1. **Tabs**: Allows the providers to choose between the Patients information and Reports.

2. **Logout Button**: For security purposes, logout to protect patient information. Not shown, in upper right hand corner.

3. **Search**: Allows providers to search by the patient’s name, Medicaid, Medicare or Marketplace ID number.

4. **Filters and Export Features**: Allows users to view all patients or filter by multiple criteria. The users will also have the ability to create a PDF document or export a detailed patient profile.
### Patient Demographics

<table>
<thead>
<tr>
<th>Member Number</th>
<th>Member Name</th>
<th>Member Address</th>
<th>Age_Gender_DOB</th>
<th>Member Phone</th>
<th>High Priority Care Opportunities</th>
<th>Risk Score</th>
<th>IP Probability Score</th>
<th>IP Stays in last 30 days</th>
<th>ER Visits within 90 Days</th>
<th>SubGroup</th>
<th>Physician</th>
</tr>
</thead>
</table>

**High Priority Care Opportunities:** Displays a count of care opportunities deemed to be of the highest importance.

**Risk Score:** Identifies the likelihood that the patient will incur cost and services in the next 12 months when compared to an average patient. An average patient has a health of 1.0. Higher values indicate the patient is more likely to need services in the future.

**IP Probability:** A percentage indicating the likelihood that a patient will have one or more inpatient confinements in the next 12 months.

**Inpatient Stays in the Last 30 Days:** A metric that captures the number of distinct inpatient hospitalizations in the last 30 days based on processed claims.

**Emergency Room Visits within 90 Days:** A metric that shows the number of distinct emergency room visits within 90 days based on processed claims.

**Subgroup:** Medicaid, Medicare, or Marketplace.

**Physician:** Displays the provider’s name and credentials.
Patient Profile

1. **Member Demographics**: Displays information about the member.

2. **All Care Opportunities**: The default landing page for patient details. Displays care opportunities or measures that indicate if a patient has or has not received treatment for a health condition.

3. **Diagnosis**: Shows primary and secondary diagnoses from claims data.

4. **Procedures**: Shows patient procedures associated with primary and secondary diagnoses.

5. **Medications**: Displays a list of medications prescribed to the patient.

6. **Lab/Observational**: Shows lab values, interpretations, and trends.

7. **Care Team**: Allows users to view the patient’s providers. Providers are labeled as Managing Doctor or Other Doctor.
Reports

Quality Measure Report
Monitor Quality Measures
This report displays all Quality Measures for your patients. It includes the compliance status of each measure and the ability to access the specific patient lists and details.

Management Reports
Patient Management Reports
This report displays all Patient Management reports for your patients. It includes the number of patients for each registry and the ability to access the specific patient lists and details.

Additional Reports
Saved Reports
This section displays all of your saved reports.

User Reference Guide
This section displays all imported reports.

Provider agrees that all health information, including that related to patient conditions, medical utilization and pharmacy utilization, available through the portal or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule.

Contact Us

allwell.mhsindiana.com
Quality Measures Report

Monitor Quality Measures Report

Users are able to view reports by selected grouping and filtering options
PCP Cost Reports

**Rx Claims Report:** This report includes members with pharmacy claims on a monthly basis. The report is available in Excel and PDF formats, provides detailed member information, provider information, detailed prescription information (such as pharmacy, units, days refill, etc.), and cost.

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

**High Cost Claims:** This report includes members with high cost claims. The report is available in Excel and PDF formats, and provides detailed member information, provider information, claim number, procedure information, diagnosis, and cost.
Network Partners
Partners and Vendors

Envolve Pharmacy Solutions: Pharmacy Benefit Manager
• 1-844-202-6824 Phone
• 1-800-977-8226 (Fax) PA Requests

Envolve Vision Benefits: Routine Eye Care Benefit & Ophthalmology Specialty Care
• 1-800-334-3937
• envolvevision.com

Envolve Dental: Dental Services
• 1-855-609-5157
• dental.envolvehealth.com

National Imaging Associates (NIA): Non-Emergent, Outpatient High-Tech Imaging
• 1-800-424-4821
• RadMD.com
AcariaHealth is a national comprehensive specialty pharmacy providing services in all specialty disease states including:

- Cystic Fibrosis
- Hemophilia
- Hepatitis C
- Multiple Sclerosis
- Oncology
- Rheumatoid Arthritis

Most biopharmaceuticals and injectables require prior authorization at: customercare@acariahealth.com
Preferred Pharmacies

- CVS
- Walmart
- University Retail
- Hometown Pharm
- Neighborcare
- Nephew
- Sam’s Club
- Kroger
- Kroger Savon
- Riley Retail
- COSTCO
- Schnuck’s
- Deaconess Family
Billing Overview
Electronic Claims Transmission

Six clearinghouses for Electronic Data Interchange (EDI) submission

Faster processing turn around time than paper submission

- Emdeon – Payer ID 68069
- Gateway
- Availity/THIN
- SSI
- Medavant
- Smart Data Solution
EDI Support

Companion guides for EDI billing requirements plus loop segments can be found on the following website: mhsindiana.com/providers/resources/electronic-transactions

For more information, contact:
Allwell from MHS c/o Centene EDI Department
1-800-225-2573, extension 25525
e-mail: EDIBA@centene.com
Claims Filing Timelines

Medicare Advantage Claims are to be mailed to the following billing address:

Allwell from MHS
P.O. Box 3060
Farmington, MO 63640-3822

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

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

♀ A clean claim is received in a nationally accepted format in compliance with standard coding guidelines, and requires no further information, adjustment, or alteration for payment.

♀ A claim will be paid or denied with an Explanation of Payment (EOP) mailed to the provider who submitted the original claim.

♀ Providers may NOT bill members for 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.
Coding Auditing & Editing

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

- American Medical Association (AMA)
- Specialty society guidance
- Clinical consultants
- Centers for Medicare & Medicaid Services (CMS)
- National Correct Coding Initiative (NCCI)

Software audits for coding inaccuracies such as:

- Unbundling
- Upcoding
- Invalid codes
Claims Reconsideration & Disputes

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

Submit reconsiderations or disputes to:

**Allwell from MHS**
Attn: Reconsiderations
P. O. Box 4000
Farmington, MO 63640-4000
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 - payspanhealth.com
Meaningful Use – Electronic Medical Records
EHR/EMR allows healthcare professionals to provide patient information electronically instead of using paper records.

Electronic Health Records/Electronic Medical Records (EHR/EMR) can provide many benefits, including:

- Complete and accurate information
- Better access to information
- Patient empowerment
Advance Directives
Advance Medical Directives

An advance directive will assist the Primary Care Provider to 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

Member’s medical records must be documented to indicate whether an advance directive has been executed.

Providers must also educate staff on issues concerning advance directives and must maintain written policies that address the rights of members to make decisions about medical care.
Fraud, Waste, and Abuse
Fraud, Waste, and Abuse

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

🌿 Preventing fraud through effective enrollment and education of physicians, providers, suppliers, and beneficiaries

🌿 Detection through data analytics and medical records review

🌿 Reporting any identified or investigated violations to the appropriate partners, including contractors, the NBI-MEDIC and federal and state law enforcement agencies, such as the Office of Inspector General (OIG), Federal Bureau of Investigation (FBI), Department of Justice (DOJ) and Medicaid Fraud Control Unit (MFCU)

🌿 Correcting fraud, waste or abuse by applying fair and firm enforcement policies, such as pre-payment review, retrospective review, and corrective action plan
Fraud, Waste, and Abuse

Allwell 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

💖 Allwell expects all its 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)
• US Criminal Codes
Effective January 1, 2016:

First-Tier, Downstream, and Related Entities (FDR), as well as delegated entities, will be 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 the health plan.
Medicare Reporting

Potential fraud, waste, or abuse reporting may be called to our anonymous and confidential hotline at 1-866-685-8664 or by contacting the Compliance Officer at 1-866-796-0530 or by email to ComplianceIN@centene.com

To report suspected fraud, waste, or abuse in the Medicare program, please use one of the following avenues:

- Fax: 1-800-223-8164
- NBI MEDIC: 1-877-7SafeRx (1-877-772-3379)
- Email: OIG.HHS.gov/fraud or HHSTips@oig.hhs.gov
- Medicare’s Fraud Hotline: 1-866-685-8664
CMS Mandatory Trainings
All contracted providers, contractors, and subcontractors are required to complete three required trainings:

- **Model of Care (MOC):** Within 30 days of joining Allwell and annually thereafter (DSNP only)
- **General Compliance (Compliance):** Within 90 days of joining Allwell and annually thereafter
- **Fraud, Waste, and Abuse (FWA):** Within 90 days of joining Allwell and annually thereafter
Model of Care training is a CMS requirement for newly contracted Medicare Providers within 30 days of execution of contract.

Model of Care training must be completed annually by each participating Provider.

The Model of Care training and attestation information is available on: Allwell.mhsindiana.com

*DSNP only*
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 Allwell

allwell.mhsindiana.com
Questions?