carolina complete health

Carolina Complete Health Overview

Transforming the health of the community one person at a time

Presentation Outline

carolina complete health

- Company Overview
- Enrollment
- Provider Credentialing and Responsibilities
- Medical Management Care Coordination
  - Prior Authorizations/Second Opinion
  - Grievances and Appeals
- Provider Services, Relations/Engagement
- Website and Secure Portal
- Claims
- Cultural Competency/Fraud, Waste and Abuse
- Questions

Carolina Complete Health

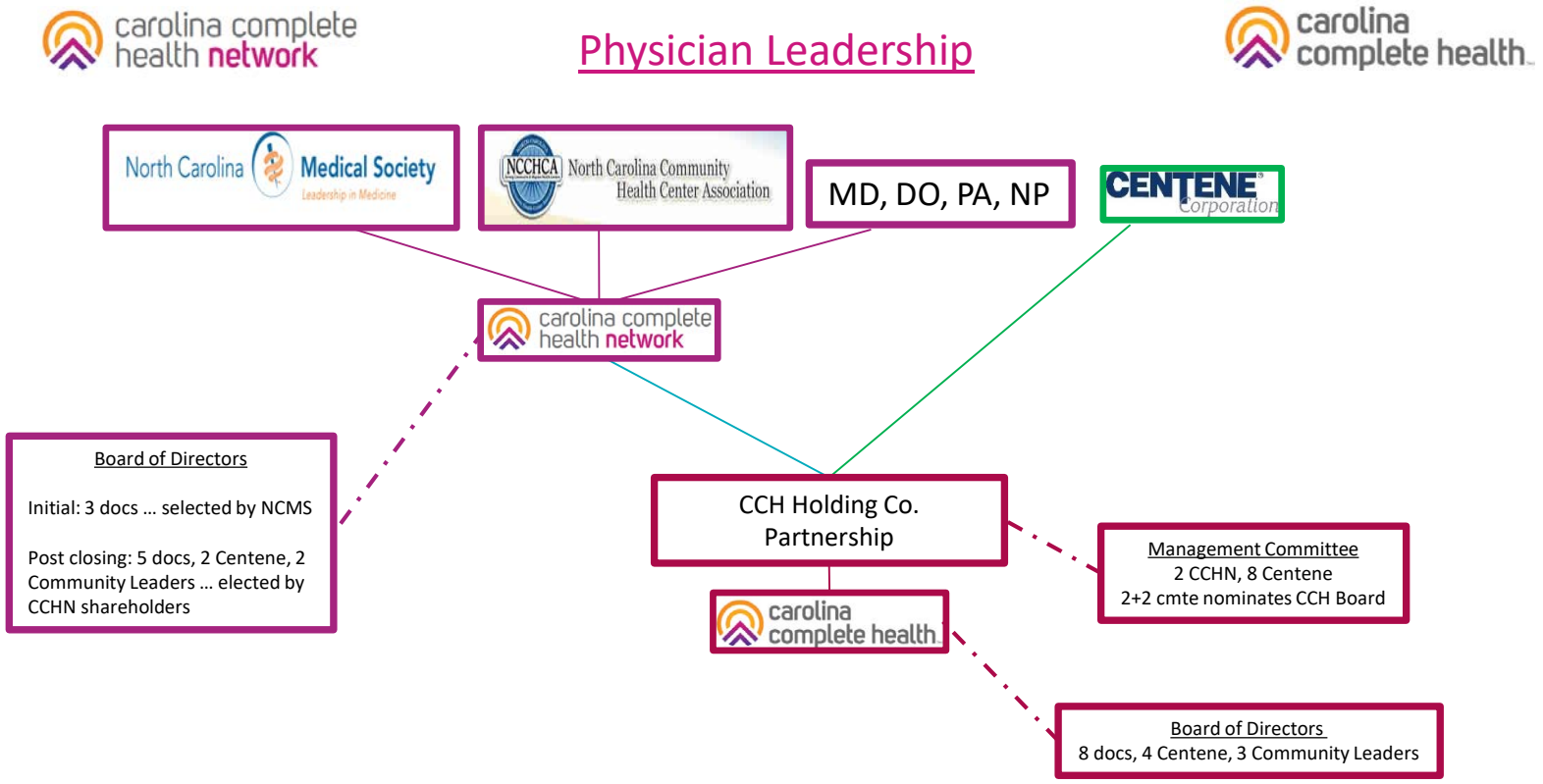
Overview

Carolina Complete Health

On January 10, 2017, a subsidiary of the **North Carolina Medical Society (NCMS)**, working in conjunction with the North Carolina Community Health Center Association (NCCHCA), and Centene Corporation entered into a joint venture agreement to collaborate on a patient-focused approach to Medicaid under the reform plan enacted in the State of North Carolina.

- Pursuant to the agreement, the joint-venture created **Carolina Complete Health**, to establish, organize and operate a physician-led Medicaid managed care health plan
- **Carolina Complete Health Network**, which is owned jointly by NCMS, Physicians, Physician Assistants, Nurse Practitioners and Community Health Centers, will provide medical management services, hold a majority on the Board of Directors and oversee the medical policies for the health plan
- Centene will manage the financial and daily operations
- *The model will facilitate providers leading health care decisions and contributing to a value-based reimbursement system to result in better health outcomes for beneficiaries at a lower cost to the state*

Carolina Complete Health Structure



Carolina Complete Health Partners

North Carolina Medical Society

carolina complete health

MEDICAL SOCIETY AT-A-GLANCE

North Carolina Medical Society
Leadership in Medicine

more than 12,000 members united statewide to advance medical science and raise professional standards

First met in 1799 and organized in 1849 with 25 physician members – *the oldest professional organization in the state*

CAROLINA COMPLETE HEALTH PARTNERSHIP

"With the changes taking place in our health care system at the state level with Medicaid reform and new programs at the national level, the NCMS remains committed to ensuring that physicians are the ones making the clinical decisions in the best interest of their patients. Our leadership views this partnership as a unique opportunity to help lead the reform process and to put patients' needs first."

– Robert W. Seligson, NCMS CEO

Carolina Complete Health Partners

North Carolina Community Health Center Association

carolina complete health

NCCHCA AT-A-GLANCE

40
health center grantees & look-alike organizations

233
clinical sites

serving nearly
500,000
patients

sites offered in
81
of North Carolina's 100 counties

more than **480,000** patients served in 2015

CAROLINA COMPLETE HEALTH PARTNERSHIP

"North Carolina Federally Qualified Health Centers (FQHCs) are key providers of primary care services to Medicaid recipients across North Carolina. The patient-centered medical home model at FQHCs, and their focus on providing a broad spectrum of services to low-income and underserved populations, make them uniquely prepared to meet the state's Medicaid reform goals.

NCCHCA believes partnering with the North Carolina Medical Society and Centene will enable FQHCs to work more closely with physician specialists and health systems in their local communities to improve patient continuity of care, quality and cost."

- E. Benjamin Money, Jr., NCCHCA CEO

Carolina Complete Health Partners

Carolina Complete Health Network

CCHN AT-A-GLANCE

WHO WE ARE In May 2016, Carolina Complete Health Network, Inc. was formed to ensure that physicians treating Medicaid beneficiaries in North Carolina have a physician-led, sustainable mechanism to provide Medicaid managed care services

WHAT WE WILL DO Working in partnership with organizations that have demonstrated success in value-based Medicaid services, we will establish, grow, and operate a physician-led provider network that uses data-driven, outcomes-based models-of-care to serve Medicaid beneficiaries in North Carolina

CAROLINA COMPLETE HEALTH PARTNERSHIP

OUR MISSION

- Provide state-of-the-art care to Medicaid beneficiaries resulting in better health at lower cost
- Empower healthcare professionals to optimize care that is outcome-driven, evidence-based, and cost-effective
- Engage healthcare professionals caring for Medicaid beneficiaries in developing best practices and medical policies

OUR FUTURE OWNERS Together the North Carolina Medical Society, Community Health Centers, physicians, physician assistants, and nurse practitioners delivering health care to North Carolina Medicaid beneficiaries

CCHN has filed an offering statement with the Securities and Exchange Commission (SEC) regarding the offering of its securities. The SEC has qualified the offering statement, which only means that CCHN may make sales of the securities described by the offering statement. It does not mean that the SEC has approved, passed upon the merits or passed upon the accuracy or completeness of the information in the offering statement. You may obtain a copy of the offering circular that is part of that offering statement at cch-network.com/invest-in-cchn/sec-filings.html. You should read the offering circular before making any investment.

Carolina Complete Health Overview

WHO WE ARE

Our local approach provides accessible, high quality and culturally sensitive healthcare services to our beneficiaries. Our integrated care coordination model can only be delivered effectively by local staff, resulting in meaningful job creation in North Carolina.

Carolina Complete Health
Street address,
Street address
Street address

www.carolinacompletehealth.com

Our Purpose

Transforming the health of the community, one individual at a time.

Our Mission

Better health outcomes at lower costs

Our Brand Pillars

Focus on individuals.
Active Local Involvement.
Whole health.

carolina complete health network

Centene Overview

carolina complete health

WHO WE ARE

St. Louis
based company founded in Milwaukee in 1984

45,400 employees

#61 Fortune 500

#36 on Forbes' **Global 2000: Growth Champions List**

#210 Fortune Global 500

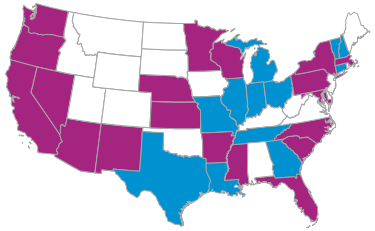
#19 on Fortune's **Change the World List**

$48.4B revenue for 2017

$60.3B Gross revenue for 2018

$14.3 billion in cash and investments

WHAT WE DO



31 states
with government sponsored healthcare programs

Medicaid (26 states)

Marketplace (17 States)

Medicare (20 States)

Correctional (12 States)

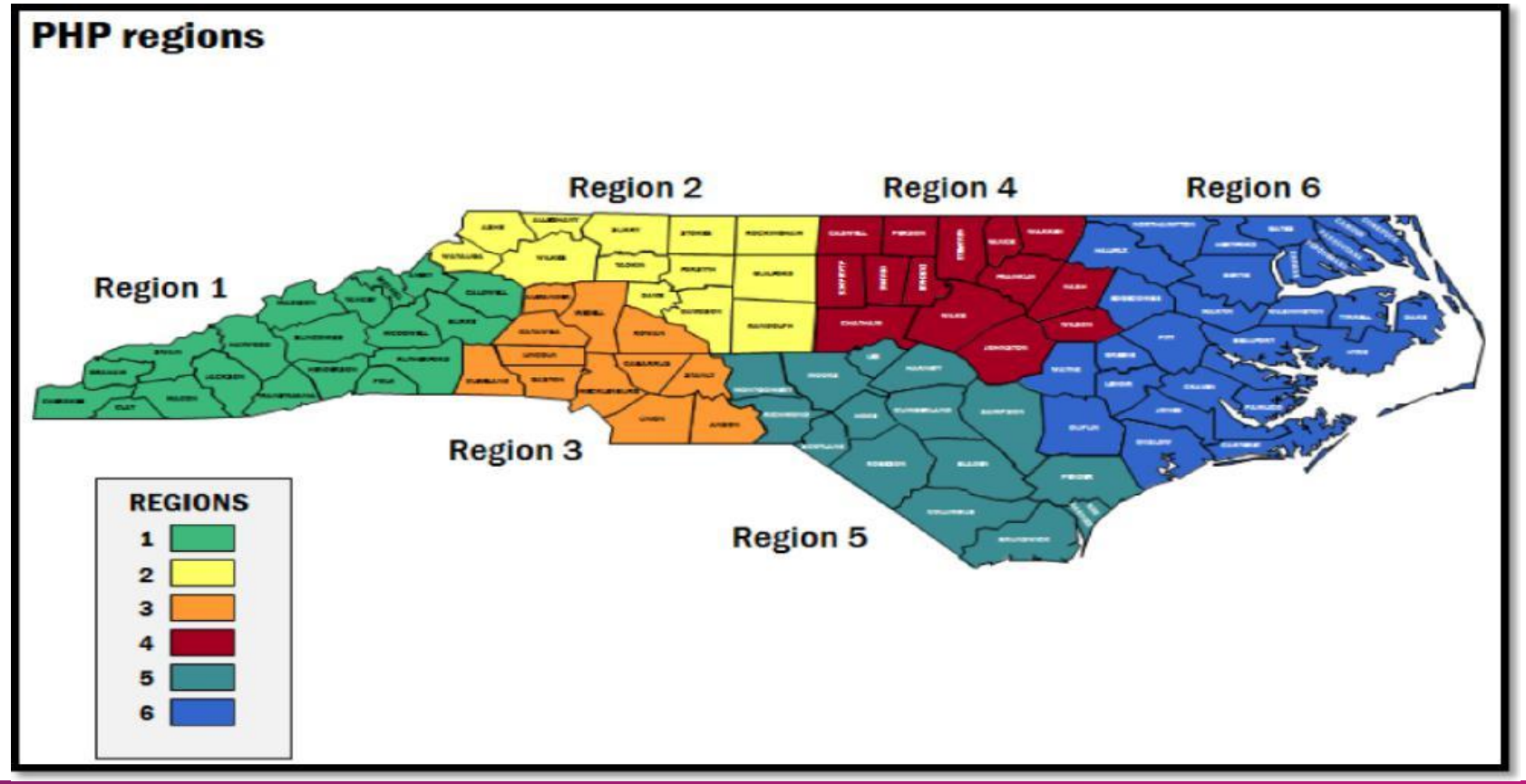
2 international markets

14.4 million members
includes 2.9 million TRICARE eligibles

~300 Product / Market Solutions

North Carolina DHHS Awarded Regions

On February 4, 2019 North Carolina Department of Health and Human Services announced the selection of Prepaid Health Plans (PHP) that will participate in Medicaid managed care when the program launches in November 2019. A regional PHP contract was awarded to Carolina Complete Health to offer plans in **Regions 3 and 5**. Carolina Complete Health is the only provider-led entity to score high enough to be awarded.



Counties in Regions 3 and 5

carolina complete health

- Region 3
  - Alexander, Anson, Cabarrus, Catawba, Cleveland, Gaston, Iredell, Lincoln, Mecklenburg, Stanly, Union

- Region 5
  - Bladen, Brunswick, Columbus, Cumberland, Harnett, Hoke, Lee, Montgomery, Moore, New Hanover, Pender, Richmond, Robeson, Sampson, Scotland

Our Approach and Goals

Our overarching goal is to help each and every Carolina Complete Health beneficiarty achieve the highest possible levels of wellness, functioning, and quality of life, while demonstrating positive clinical results.

Integrated Care

- Strong support for the integration of both physical, behavioral, and LTSS and HCBS services
- Assisting beneficiaries in achieving optimum health, functional capability, and quality of life

Coordination of Care

- Assist beneficiaries with locating a Provider
- Coordinate requests for out-of-network providers by determining need/access issues involved

Continuity of Care

- Continuity of personal relationships, recognizing that an ongoing relationship between beneficiaries and health providers and community providers is the foundation that connects care over time and bridges discontinuous events
- Continuity of clinical management

Carolina Complete Health

Enrollment

Medicaid Managed Care Enrollment

- North Carolina Medicaid and NC Health Choice populations will be mandatorily enrolled in PHPs. The following will be exceptions to those enrolled—populations may be "exempt" (up to beneficiary to choose) or "excluded" (No option to enroll):

Excluded Examples

- Duals for whom NC Medicaid is limited to Medicare premiums and cost sharing
- Medically needy North Carolina Medicaid beneficiaries
- Beneficiaries participating in the NC Health Insurance Premium Payment (HIPP) program
- Beneficiaries enrolled under the Medicaid Family planning program
- Inmates of prisons
- Beneficiaries being served through the CAP/C or CAP/DA
- PACE participants

Exempt Examples

- Until BH/IDD Tailored Plans are available, beneficiaries with a serious mental illness, a serious emotional disturbance, a severe SU disorder, or who have survived a traumatic brain injury are exempt
- Exempt populations include beneficiaries of federally recognized tribes, including the Eastern Band of Cherokee Indians (EDCI)

Carolina Complete Health Beneficiary ID Card

- Beneficiaries should present both their Carolina Complete Health ID card and a photo ID each time services are rendered by a provider. As a provider for our Carolina Complete Health, if you are not familiar with the person seeking, please ask to see photo identification.

Need copy of front of ID card here

Need copy of back of ID card here

Checking Eligibility for Carolina Complete Health

Providers should always verify beneficiary eligibility:

- When a beneficiary schedules an appointment
- When the beneficiary arrives for the appointment

Verifying eligibility can be done via:

- Secure Provider Portal at www.carolinacompletehealth.com
- Automated beneficiary eligibility IVR system at xxx-xxx-xxxx(need a phone #)
- Calling Provider Services at 1-833-552-3876
- **PCPs should check that a beneficiary is assigned to their patient panel – this can be done via our Secure Provider Portal. PCPs can still administer service if the beneficiary is not and may wish to have beneficiary assigned to them for future care.**

Carolina Complete Health

Provider Credentialing
And Responsibilities

Provider Credentialing – Practitioner and Facility

- ✓ Carolina Complete Health (CCH) will maintain a high quality healthcare delivery system with adequate access to credentialed providers for all beneficiaries meeting all DHHS criteria for specialties, drive times, availability, and timely access standards
- ✓ For consideration to participate in the Carolina Complete Health network, all individual practitioners who have an independent relationship with Carolina Complete Health must first complete the centralized credentialing process as outlined in the NC Medicaid Special Bulletin entitled *Centralized Credentialing Vendor Selected for NC Medicaid* published January 2019.
- ✓ Carolina Complete Health will make the final quality determination and will verify that all network providers are credentialed before listing them in Carolina Complete Health's provider directory, handbooks, or other marketing materials.
- ✓ Re-Credential in accordance with state and health plan standards

Provider Responsibilities

- The Provider is responsible for supervising, coordinating, and providing all authorized care to each assigned beneficiary. Carolina Complete Health (CCH)is committed to achieving Medical Home by using patient-centered and coordinated Care Management in addition to honoring the Tier 3 AMH delegated credentialing.
- PCPs are encouraged to refer to another participating Provider when care is needed beyond the scope of what PCP can provide.
- PCPs will work with CCH Care Coordination to ensure appropriate level care is rendered and or beneficiaries of special populations are referred to appropriate providers to obtain Medically Necessary Care
- PCPs are required to maintain sufficient access to facilities and personnel to provide services 24 hours a day, 365 days a year (covering physician, answering service, triage service, etc.)
- Providers must treat beneficiaries with fairness, dignity, and respect in a culturally competent manner
- Providers should identify special beneficiary needs while scheduling an appointment (wheelchair and interpretive linguistic needs, non-compliant individuals or those with cognitive impairments)

Provider Responsibilities

- Providers must not discriminate against beneficiaries on the basis of race, color, national origin, disability, age, sex, religion, mental or physical disability, or limited English proficiency
- Providers must maintain the confidentiality of beneficiaries' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality
- All Providers and their employee and administrators of a facility are mandatory reporters of suspected physical and/or sexual abuse and neglect of CCH beneficiaries and should be reported to Carolina Complete Health
- Providers are encouraged to ensure beneficiaries execute an Advance Directive and put into beneficiary's medical record. Providers must comply with federal and state laws regarding Advance Directives
- PCPs reserve the right to determine the number of beneficiaries they can accept in their panel of beneficiaries
- Specialists will maintain communication with PCP and coordinate care plans
- All Providers shall maintain accurate and complete medical records documenting all services provided and allow Carolina Complete Health and regulatory bodies access to such records.

Provider Responsibilities

- Providers must communicate with CCH regarding closing of panel, change of address, voluntary termination, addition of practitioners, and other important practice matters
- Providers can check the secure portal to determine whether patient has any other insurance that may be primary so that the Provider may bill the correct insurance company. Any information gathered by the physician office regarding other insurance can be relayed to your network specialist so that it may be updated in our systems.
- Providers should disclose to Carolina Complete Health, on an annual basis, any physician incentive plan (PIP) the provider or provider group may have with physicians either within the group practice or other physicians not associated with the group practice even if there is no substantial financial risk between Carolina Complete Health and the physician or physician group.
- Providers shall participate in Carolina Complete Health data collection initiatives, such as HEDIS and other contractual or regulatory programs.
- Providers must not discriminate against beneficiaries on the basis of race, color, national origin, disability, age, sex, religion, mental or physical disability, or limited English proficiency

ADA Compliant Access

Carolina Complete Health will ensure compliance with ADA accessibility guidelines. Where applicable, this will include:

- Parking
- Pathway(s) to entry
- Entrance to the building and/or office

What are Critical Incidents?

- Abuse, which includes the infliction of injury, unreasonable confinement, exploitation, intimidation, punishment, mental anguish, environmental hazard, or sexual abuse of a beneficiary. Types of abuse include, but are not necessarily limited to:
  - Physical abuse
  - Psychological abuse
  - Sexual abuse
  - Verbal abuse
  - Neglect
  - Seclusion
  - Exploitation
  - Restraint
  - Service interruption
  - Medication errors

Carolina Complete Health

Medical Management

Care Coordination

Medically Necessary

As found in your Product Attachment to your Agreement:

- **Medically Necessary Services (also referred to as Medical Necessity)** — means those Covered Services that are, under the terms and conditions of the State Contract, determined through Health Plan or Payer utilization management to be:
  - appropriate and necessary for the symptoms, diagnosis or treatment of the condition of the Covered Person;
  - provided for the diagnosis or direct care and treatment of the condition of Covered Person enabling the Covered Person to make reasonable progress in treatment;
  - within standards of professional practice and given at the appropriate time and in the appropriate setting;
  - not primarily for the convenience of the Covered Person, the Covered Person's physician or other provider; and
  - the most appropriate level of Covered Services, which can safely be provided.

- Determination of Medical Necessity for covered care and services, whether made on a Prior Authorization, Concurrent Review, Retrospective Review, or exception basis, must be documented in writing. The determination is based on medical information provided by the beneficiary, the beneficiary's family/caretaker and the Primary Care Practitioner, as well as any other Providers, programs, agencies that have evaluated the beneficiary. All such determinations must be made by qualified and trained Health Care Providers. A Health Care Provider who makes such determinations of Medical Necessity is not considered to be providing a health care service under this Agreement.
- CCH has adopted utilization review criteria developed by McKesson InterQual® products to determine medical necessity for healthcare services.

Critical Incidents

- A critical incident/potential quality of care issue is any alleged act or behavior that may be detrimental to the quality or safety of patient care, is not compliant with evidence-based standard practices of care, or that signals a potential sentinel event, up to and including death of a beneficiary.

- Carolina Complete Health employees (including medical management staff, customer service staff, complaint coordinators, etc.), panel practitioners, facilities or ancillary providers, beneficiaries or beneficiary representatives, medical directors, or the BOD may advise the Quality Improvement (QI) Department of potential quality of care issues.

- Adverse events may also be identified through claims-based reporting and analyses. Potential quality of care issues require investigation of the factors surrounding the event in order to make a determination of their severity and need for corrective action, up to and including review by the Peer Review Committee as indicated. Potential quality of care issues received in the QI department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

Care Coordination

Carolina Complete Health's Care Coordination model is designed to help beneficiaries obtain needed services from our array of covered service or from the community services at the right time and the right place. It is a multi-disciplinary care management team inclusive of CCH and Advanced Medical Home (AMH) and LHD (Local Health Department) providers, focused on:

- A holistic approach to yield better outcomes
- Promoting continuity of care
- Increase positive medical outcomes—highest levels of wellness, functioning, and quality of life
- Ensuring that each beneficiary receives quality, comprehensive care services within the community
- Early identification, needs assessment, person-centered care plans that includes beneficiary/family education, evidence-based practices, trauma-informed care, and actively links the beneficiary to providers and support services
- Rapid and thorough identification and assessment of program participants, especially beneficiaries with special health care needs
- Discharge planning and personalized treatment plans
- Contribute to the reduction in costs to the Long Term Services and Supports Program

Role of Care Coordinator in LTSS

- The goals of DHHS and Carolina Complete Health are to improve overall health and independent living outcomes while slowing the rate of cost growth over time. This will be accomplished by providing the right service, in the right amount, in the right setting, at the right time. CCH will work with AMHs and will focus on ensuring consumers receive the preventive services, screenings and independent living services they need, helping consumers manage their chronic conditions and reducing any unnecessary or duplicative services.
  - Care Managers (CM) will work collaboratively with AMH providers and/or co-lead the creation of the Comprehensive Care Plan (CCP) depending on AMH capability for complex Beneficiaries receiving LTSS services
  - CM will coordinate support AMHs to coordinate and assist beneficiaries in gaining access to needed services—covered, non-covered, medical, social, housing, educational, and other services and supports
  - If CCH is leading Care management then the CM with support the beneficiary to identify strengths, goals, development of CCP, evaluations, reassessments, and leveling of care. Service Plans are reviewed with beneficiaries during regularly scheduled face-to-face meetings
  - The CM will further support the AMH in providing referrals to community resources if the beneficiary is no longer Medicaid eligible
  - Should a beneficiary's enrollment change to another Managed Care Plan, the Care Coordinator must coordinate a transfer between the managed care plans. This includes transferring care coordination records from the prior twelve (12) months to the new managed care plan.

Role of Care Coordination/ Behavioral Health Coordination

carolina complete health

- ✓ Our approach includes immediate beneficiary (or parent/guardian, for minors) engagement, from initial assessment through coordination with AMHs for planning and implementation of an individualized, holistic care plan.
- ✓ CCH will ensure that Care plans will incorporate both covered and non-covered services to reflect the range of health, behavioral health (BH), functional, social, and other needs that are within the scope of BH population covered (not TBI or severe BH)
- ✓ Work with delegated AMHs on holistic care of eligible beneficiaries
- ✓ Pay careful attention both to compliance with prescribed medications as well as potential impact of each medication on all PH and BH conditions.
- ✓ Rapid and thorough identification and assessment of program participants, especially beneficiaries with special health care needs

Role of Provider in Service Planning

- Provider is responsible for supervising, coordinating and providing authorized services, and complying with the associated requirements of their AMH Tier assignment
- May participate in Health Education Advisory Committee within the community to advise on the health and education needs of beneficiaries.
- The provider will comply with beneficiary Grievance, Appeal, and DHHS Fair Hearing Process, reporting requirements.
- Provider will acknowledge services and supports, which are authorized, to fulfill beneficiaries' CCP

CCH and Advanced Medical Homes

- Carolina Complete Health (CCH) is considered a PHP or Prepaid Health Plan.
- DHHS has a strong preference for local care management (CM) to be performed at the site of care
- DHHS established a system of delegated CM through Advanced Medical Homes (AMH)
- DHHS assigns providers to one of 4 tiers based on the providers capabilities and infrastructure to perform and track care management of the populations served
- For Tier 3 AMH practices, CCH will delegate CM responsibilities and functions in support of DHHS's goal of local CM
- If a terminated provider is an AMH/PCP provider, CCH will notify the beneficiary of the procedures for selecting an alternative AMH/PCP. If the beneficiary does not actively select one within 30 days, the beneficiary will be assigned to a new AMH/PCP

EPSDT

- Carolina Complete Health (CCH) uses integrated methods to promote EPSDT to all beneficiaries and providers in an effort to remain compliant with State and Federal requirements.
- Our Performance Improvement Team will analyze our EPSDT performance and develop targeted, data-driven improvement recommendations.
- CCH will have: Data and technology to support outreach, tracking and evaluation; Comprehensive beneficiary education, outreach, and reminders; Provider requirements and education; Support and interventions to assist provider in ensuring all assigned beneficiaries receive needed EPSDT services in a timely manner; and, Regular evaluation of program performance and addressing of improvement opportunities.
- If after an EPSDT screen, a provider suspects developmental delay and is aware that the child is not yet receiving services, the provider should refer the child for Early Intervention Program services.
- Perform EPSDT screenings at every opportunity such as during a sports physical or sick visit
- Through our Provider Portal providers can access EPSDT care gap alerts when a child is not current with the EPSDT periodicity schedule or has other gaps in care.

Into the Mouths of Babes (IMB)

- CCH supports the IMB program which trains medical providers to deliver preventive oral health services to young children insured by NC Medicaid.
- Services are provided from the time of tooth eruption until age 3 ½ (42 months)
- Oral Preventive Procedures consist of 3 parts: Oral Evaluation and Risk Assessment; Counseling with Primary Care Givers; Application of Topical Varnish
- Medicaid-insured children may have the procedure a maximum of six times from tooth eruption until age 42 months.
- Procedure is recommended every 3-6 months—minimally a 60-day time interval between procedures
- NC Oral Health Section offers a 1-hour professional and staff training session on IMB in which CME credit is awarded. Contact Kelly Close at 919-707-5485
- Dentists and medical professionals may both provide preventive oral health services and receive Medicaid payment

Additional Offered Programs

- Carolina Complete Health *"My Health Pays"* program
- Vaccines for Children (VFC) Program
  - NC Immunization Registry
- Nurse Advice Line
- Start Smart for Your Baby®

- Population Health Programs including:
  - Asthma
  - Diabetes
  - Hypertension
  - Tobacco Cessation
  - Depression/Anxiety
  - Low Birth Weight
  - Infant Mortality
  - Obesity
  - Early Childhood Health & Development

MemberConnections®

MemberConnections®

- Liaisons between health plan and our beneficiary communities.
- Coordinate home visits for high risk beneficiaries including ConnectionsPlus® phones delivery.
- Conduct beneficiary orientations and advisory committees.
- Represent Carolina Complete Health in community with key stakeholder groups.
- Participate in local boards, task forces, and advisory committees.

Prior Authorizations

- Failure to obtain required approval or pre-certification may result in denial of claims
- CCH will monitor statistics regarding PA and work to minimize unnecessary PA requests
- All services are subject to benefit coverage, limitations, and exclusions as described in applicable plan coverage guidelines—Limited items need prior authorization
- Carolina Complete Health providers are contractually prohibited from holding any Carolina Complete Health beneficiary financially liable for any service administratively denied by CCH for the failure of the Provider to obtain timely authorization
- CCH has adopted utilization review criteria developed by McKesson InterQual, the American Society of Addiction Medicine (ASAM) and the State of North Carolina Department of Health and Human Services as indicated.

Disclaimer: An authorization is not a guarantee of payment. Beneficiaries must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with PA as per Plan policy and procedures.

Prior Authorizations

- Prior Authorization requirements can be checked via the “Pre-Auth Needed?” tool on the For Providers page of the CCH website.
- Prior Authorizations can be submitted by:
  - Electronically through the Secure provider Portal
  - Fax Prior Authorization fax forms posted on www.carolinacompletehealth.com (in development)
  - Call xxx-xxx-xxxx (or the Provider Services line at xxx-xxx-xxxx)

Second Opinion

- Beneficiaries or a Healthcare Professional, with the beneficiary's consent, may request and receive a second opinion from a qualified professional with the CCH network. If there is not an appropriate Provider to render the second opinion with the network, the beneficiary may obtain the second opinion from an out-of-network provider at no cost to the beneficiary. Out-of-network and in-network Providers require prior authorization by CCH when performing second opinions.

Service Request Grievance Process

- A beneficiary, beneficiary's authorized representative, or beneficiary's Provider (with written consent from the beneficiary) may file an Appeal or Grievance. A grievance is a spoken or written expression of dissatisfaction sent to Carolina Complete Health about any action of Carolina Complete Health or a provider in the network.

- Appeals include, but not limited to: Quality of Care; Personal behavior of provider or employee; failure to respect a beneficiary's rights; harmful administrative process or operation

- Carolina Complete Health will acknowledge with letter within 5 days and a letter informing the beneficiary of our decision within 30 days

- In addition to the two levels of grievances, there is a State Fair Hearing process. Beneficiaries do not have to exhaust the complaint or grievance process prior to filing a request for a State Fair Hearing. External review of second level grievances may also occur.

Provider Complaints

- A Complaint is a verbal or written expression by a provider that indicates dissatisfaction or dispute with Carolina Complete Health policies, procedure, claims, or any aspect of Carolina Complete Health functions.
- Carolina Complete Health establishes and maintains written policies and procedures for the filing of provider Grievances and Appeals. Providers have the right to file a Complaint with us.
- Provider Complaints will be resolved within thirty (30) calendar days, with a status update provided after fifteen (15) days. A provider shall have the right to file a complaint with us regarding provider payment issues and/or Utilization Management decisions.
- Complaints may be submitted in writing via mail or fax, or orally by contacting Provider Services.

Carolina Complete Health

Provider Services

Provider Relations/Engagement

Provider Services

Carolina Complete Health's Beneficiary/Provider Services department includes trained Provider Relations/Engagement staff who are available to respond quickly and efficiently to all provider inquiries or requests including, but not limited to:

- Credentialing/Network Status
- Claims
- Request for adding/deleting physicians to an existing group
- Provider analytics and care gap closure for HEDIS performance
- Review physician/practice experience for quality and financial risk arrangements under the Value Based Contracting (VBC) model of contracting

By calling Carolina Complete Health Provider Services at 1-833-552-3876, providers will be able to access real time assistance for all their service needs.

Provider Relations/Engagement

- Each provider will have a CCH Provider Network Specialists assigned to them. This team serves as the primary liaison between the Plan and our provider network and is responsible for:
- Provider Education
- HEDIS/Care Gap Reviews
- Financial Analysis on P4P or risk arrangement in VBC
- Assisting Providers with EHR Utilization
- Demographic Information Update
- Initiate credentialing of a new practitioner
- Facilitate to inquiries related to administrative policies, procedures, and operational issues
- Monitor performance patterns
- Contract clarification
- Beneficiary/Provider roster questions
- Assist in Provider Portal registration and Payspan

Provider Relations Territory Assignments

[Map

Of

Territories]

IVR Features

Beneficiary Functionality

- Verify PCP demographic information
- Obtain benefit information such as office, emergency, inpatient and outpatient co-payments
- Check claims status

Provider Functionality

- Verify beneficiary demographic information
- Check claim status
- Obtain benefit information such as office, emergency room, inpatient and outpatient coverage, long-term care, and community services
- Obtain co-payment information when checking beneficiary eligibility
- Connect to care coordinators and referral specialist
- Connect with our vendors who supply medically necessary covered services

Carolina Complete Health

Website and Secure Portals

Non-Secure Provider Portal

Carolina Complete Health's website is located at www.carolinacompleteheatlh.com

Providers can find the following information on the Non-secure website:

- Prior Authorization List
- Forms
- CCH's Plan News
- Clinical Guidelines
- Provider Bulletins
- Contract Request Forms
- Provider Consultant Contact Information

Provider Manual

The provider manual contains comprehensive information about Carolina Complete Health operations, benefits, billing, and policies and procedures. The most up-to-date version can always be viewed from our website

www.carolinacompletehealth.com

You will be notified of updates via notices posted on our website and/or in Explanation of Payment (EOP) notices.

Website and Secure Portal Tools

Secure Portal

On the homepage, select the Login link on the top right to start the registration process. Through the site you can:

- Check beneficiary eligibility
- View the PCP panel (patient list)
- Verify claim status
- View payment history
- Verify authorization status
- Contact us securely and confidentially
- Determine payment/check clear dates
- View PCP Quality Incentive Report
- View Patient Analytics
- View beneficiaries' health record
- View and submit claims and adjustments
- Verify proper coding guidelines.
- View and submit authorizations
- View beneficiary gaps in care
- Add/Remove account users
- Add/Remove TINs from a user account
- View and print Explanation of Payment
- View Provider Analytics

Web-Based Tools

Web-Based Tools

- Public site at www.carolinacompletehealth.com

- Provider Information for Medical Services
  - Provider Manual and Billing Manual
  - Prior Authorization Code Checker
  - Operational forms such as Prior Authorization Forms, Notification of Pregnancy forms etc…
  - Clinical Practice Guidelines
  - Provider Newsletters and Announcements
  - Plan News
  - Find a Provider

- Carolina Complete Health is committed to enhancing our web based tools and technology, provider suggestions are welcome

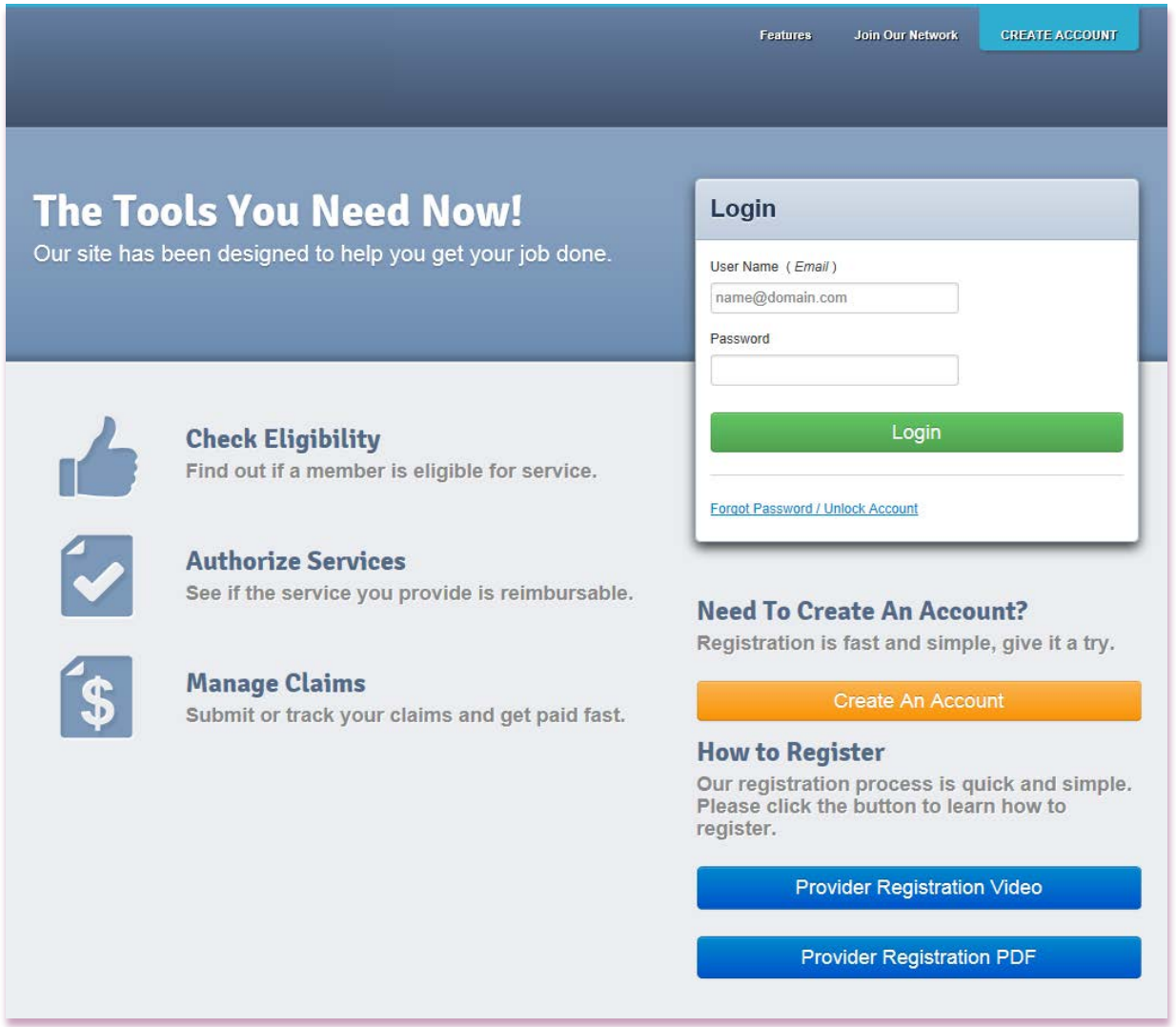
- Contact Provider Services at xxx-xxx-xxxx

Secure Provider Portal

Secure Provider Portal:

- Beneficiary Eligibility & Patient Listings
- Health Records & Care Gaps
- Authorizations
- Claims Submissions & Status
- Corrected Claims & Adjustments
- Payments History
- Monthly PCP Cost Reports

Registration is free and easy, contact your Provider Network Specialist to get started!!!



Secure Provider Portal

- PCP reports available on CCH's secure provider web portal are generated on a monthly basis and can be exported into a PDF or Excel format.
- **PCP Reports include:**
  - Patient List with HEDIS Care Gaps
  - Emergency Room Utilization
  - Rx Claims Report
  - High Cost Claims

Carolina Complete Health

Claims

Provider Payments

- Unless specifically contracted otherwise, Carolina Complete Health's policy is to pay clean claims for eligible beneficiaries at the lesser of billed charges (unless specifically prohibited by Statutory/Regulatory language) or the provider's individually negotiated rate as memorialized in the Provider's Participating Provider Agreement with Carolina Complete Health in accordance with the beneficiary's benefits of their respective benefit plan.

Claims

Four clearinghouses for Electronic Data Interchange (EDI) submission Carolina Complete Health Medical Payer ID 68069

- Emdeon
- Gateway EDI
- Envoy
- WebMD

Additional information can be found on CCH's website: www.carolinacompletehealth.com

For more information please contact:

Centene EDI Department
1-800-225-2573, extension 25525
e-mail: EDIBA@centene.com

Claims

- Clean Claim
  - A claim that is received for adjudication in a nationally accepted format in compliance with standard coding guidelines and does not have any defect, impropriety, lack of any required documentation or particular circumstance requiring special treatment that prevents timely payment
- Exceptions
  - If a claim meets the definition above, but either of the following circumstances apply, it will not be considered a clean claim
    - A claim for which fraud is suspected
    - A claim for which a third party resource should be responsible

Claims

carolina complete health

Claim Payment

- Clean claims will be adjudicated (finalized paid or denied) 95% within 15 calendar days and 99% within 30 calendar days following receipt of the claim
- Nursing Facility and Hospice clean claims will be adjudicated (finalized paid or denied) within 30 days, following receipt of the claim

Timely Filing Guidelines

- Initial Filing – 90 calendar days from the date of service (Professional)
- Initial Filing – 90 calendar days from the date of discharge (Hospital)
- Coordination of Benefits (Carolina Complete Health as secondary) – 365 calendar days from the primary payer's determination
- Corrected/Reconsideration/Disputes – 180 calendar days from the receipt of payment/denial notification

Claims - Disputes

A claim dispute should only be made when a provider has received an unsatisfactory response to their request for reconsideration.

- The claim dispute form can be located on Carolina Complete Health's web portal at www.carolinacompletehealth.com
- A response to an approved adjustment will be provided by way of check with an accompanying Explanation of Payment (EOP)
- Submit disputes to:

Carolina Complete Health
Attn: Disputes
P. O. Box 8030
Farmington, MO 63640-8030

Claims and Correspondence

Paper Claims, Corrected Claims, Claims Disputes, Request for Reconsideration mailing address:

Carolina Complete Health

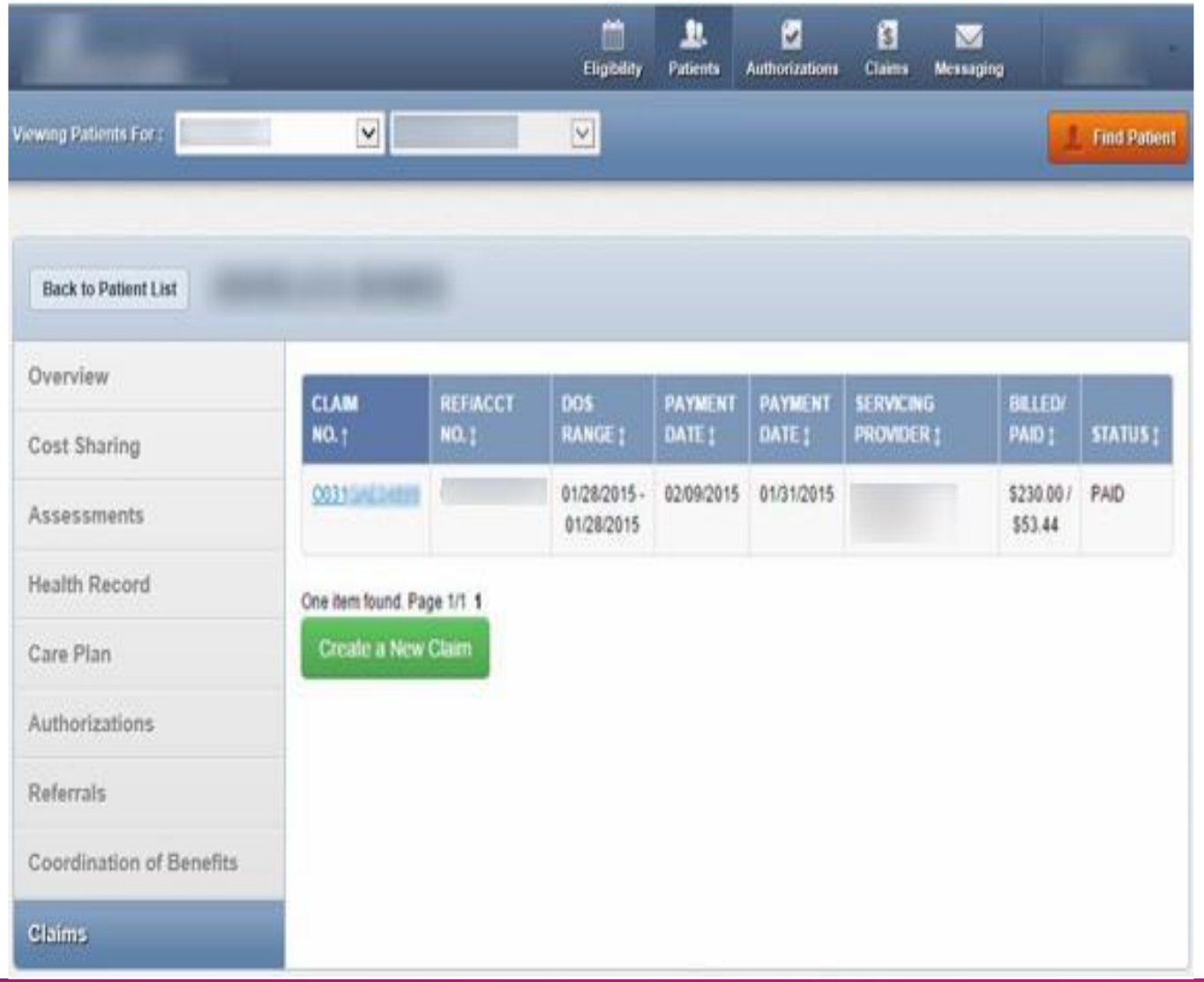
Attn: Claims Department (*or Corrected Claims or Claims Disputes, respectively*)

P. O. Box 8030

Farmington, MO 63640-8030

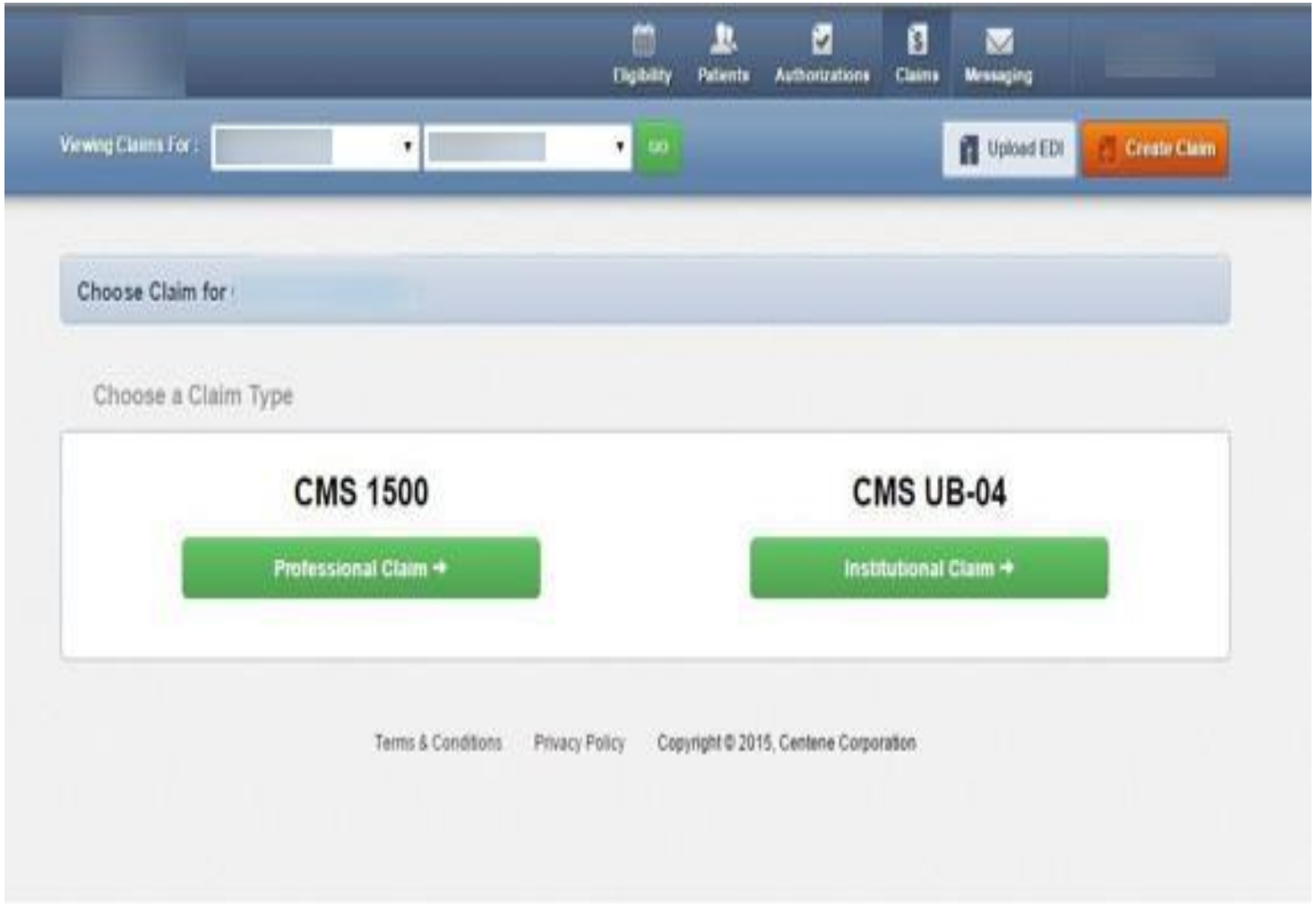
Claims Submissions – Professional

To submit a new professional claim, select the green “Create a New Claim” button within the patient record.



Claims Submissions - Professional

When prompted, click on the Professional Claim button.

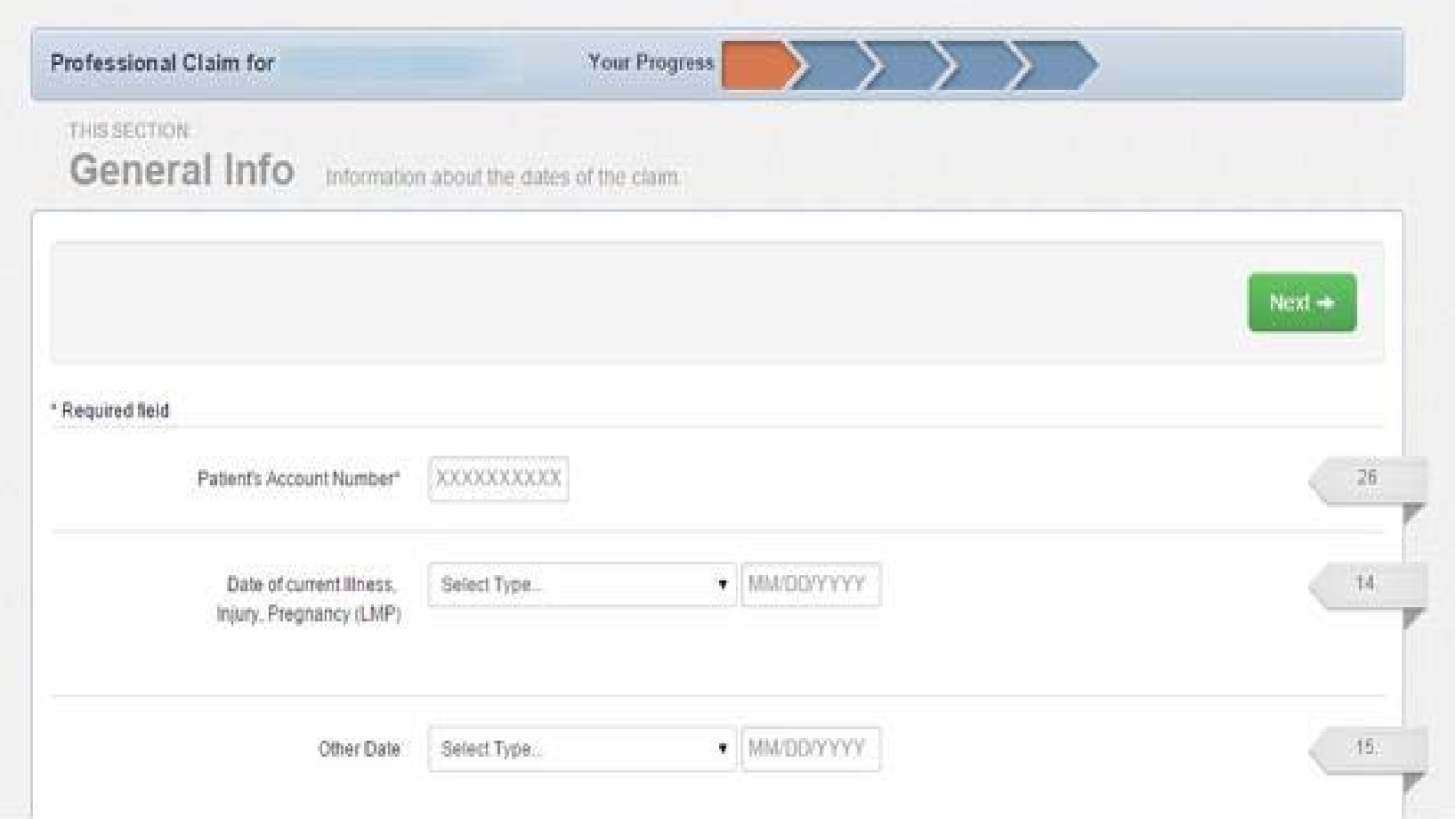


Claims Submissions – Professional

In the General Info section, populate the Patient's Account Number, and other information related to the patient's condition by typing into the appropriate fields.

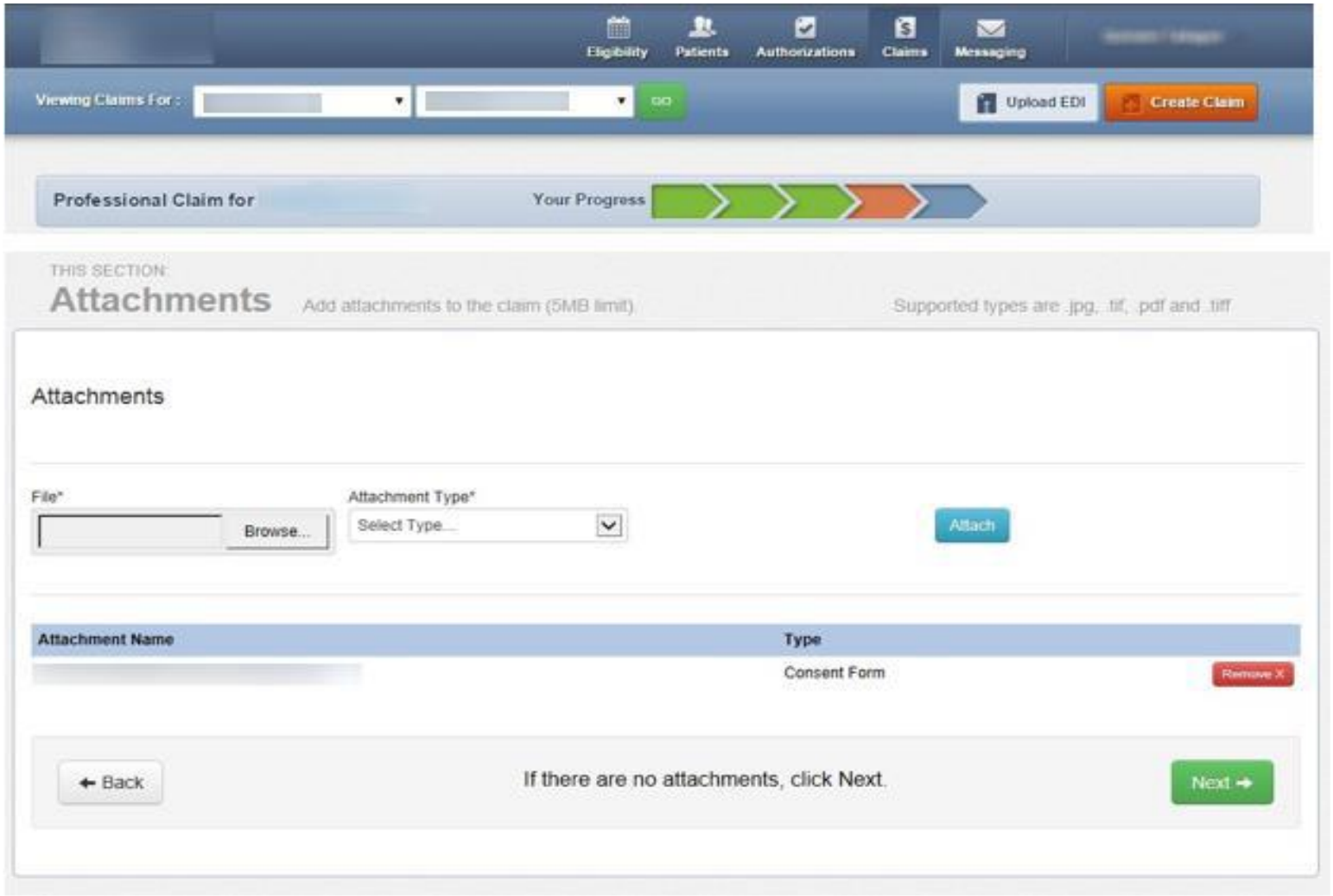
Then click Next, and follow the prompts to add diagnosis codes, coordination of benefits information, and other required information.

Note that the numbers along the right side represent the box number on the paper claim.



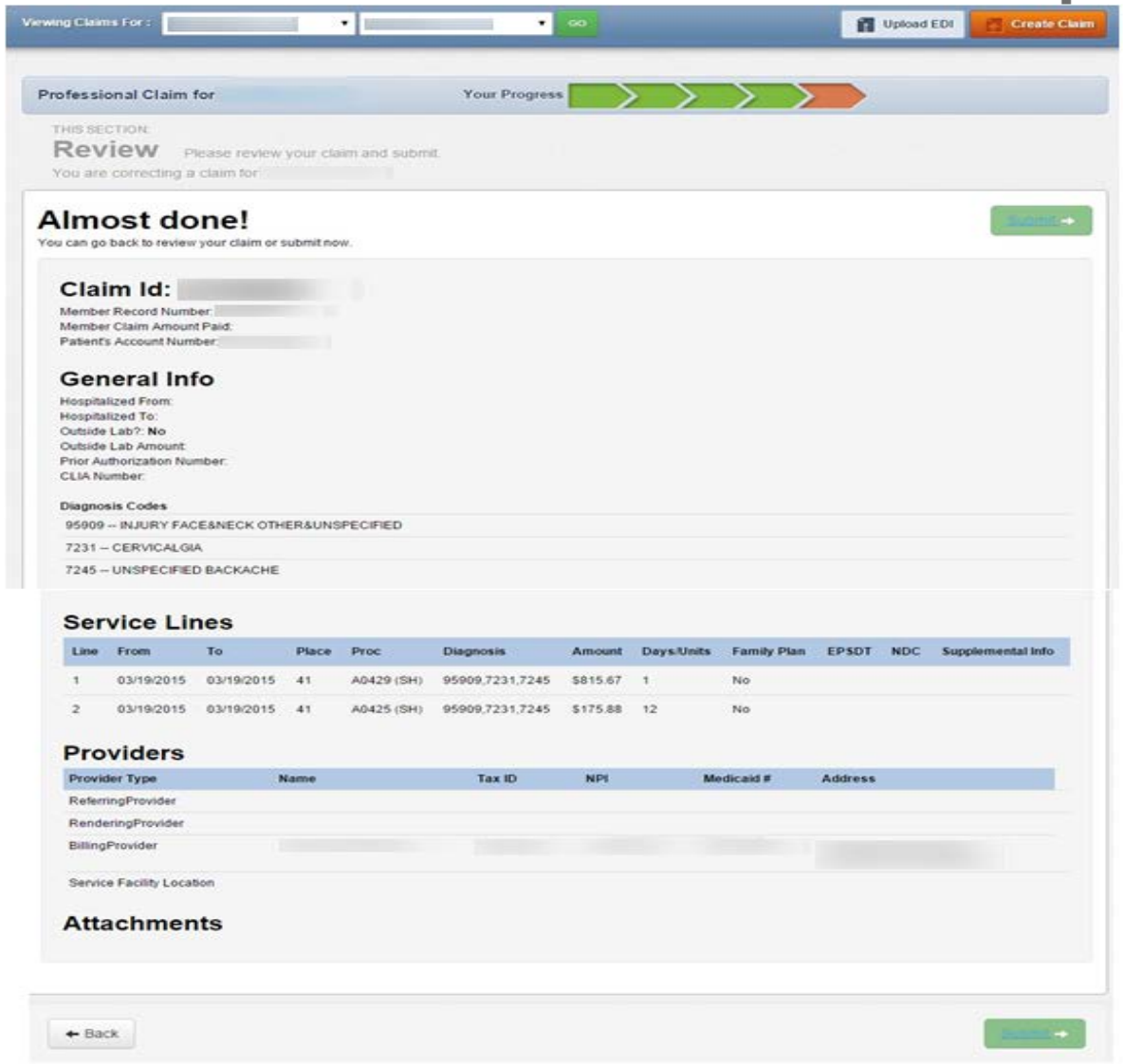
Claims Submissions - Professional

If you have medical records or other documentation that needs to be attached to the claim, submit it using the Attachments screen. You may use the Browse button to attached any documents pertinent to the claim. If you have no attachments, you may skip this section.



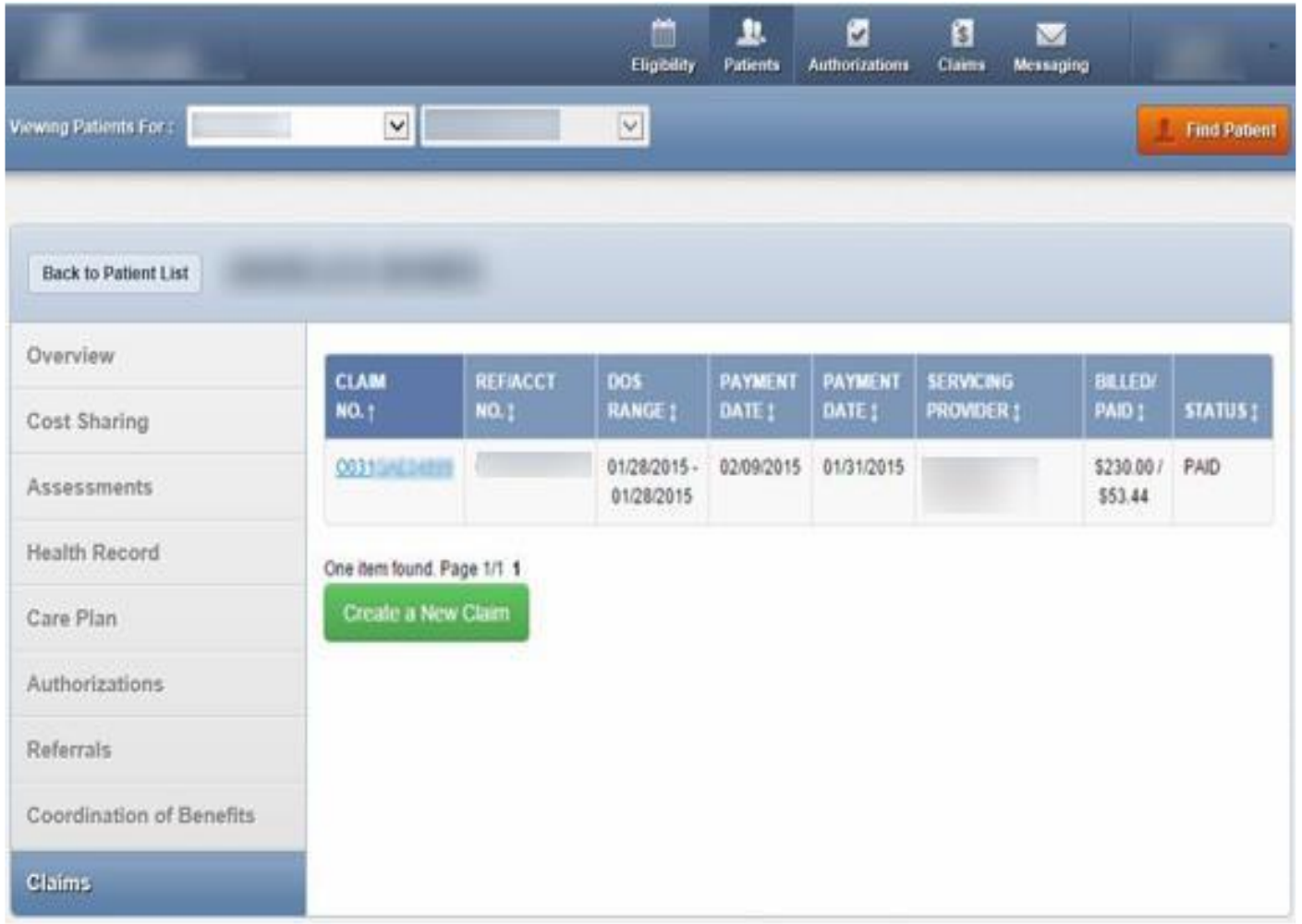
Claims Submission - Professional

Your final step is to review the entire claim. Once you have confirmed that everything is correct, click the green Submit button in the bottom, right-hand corner.



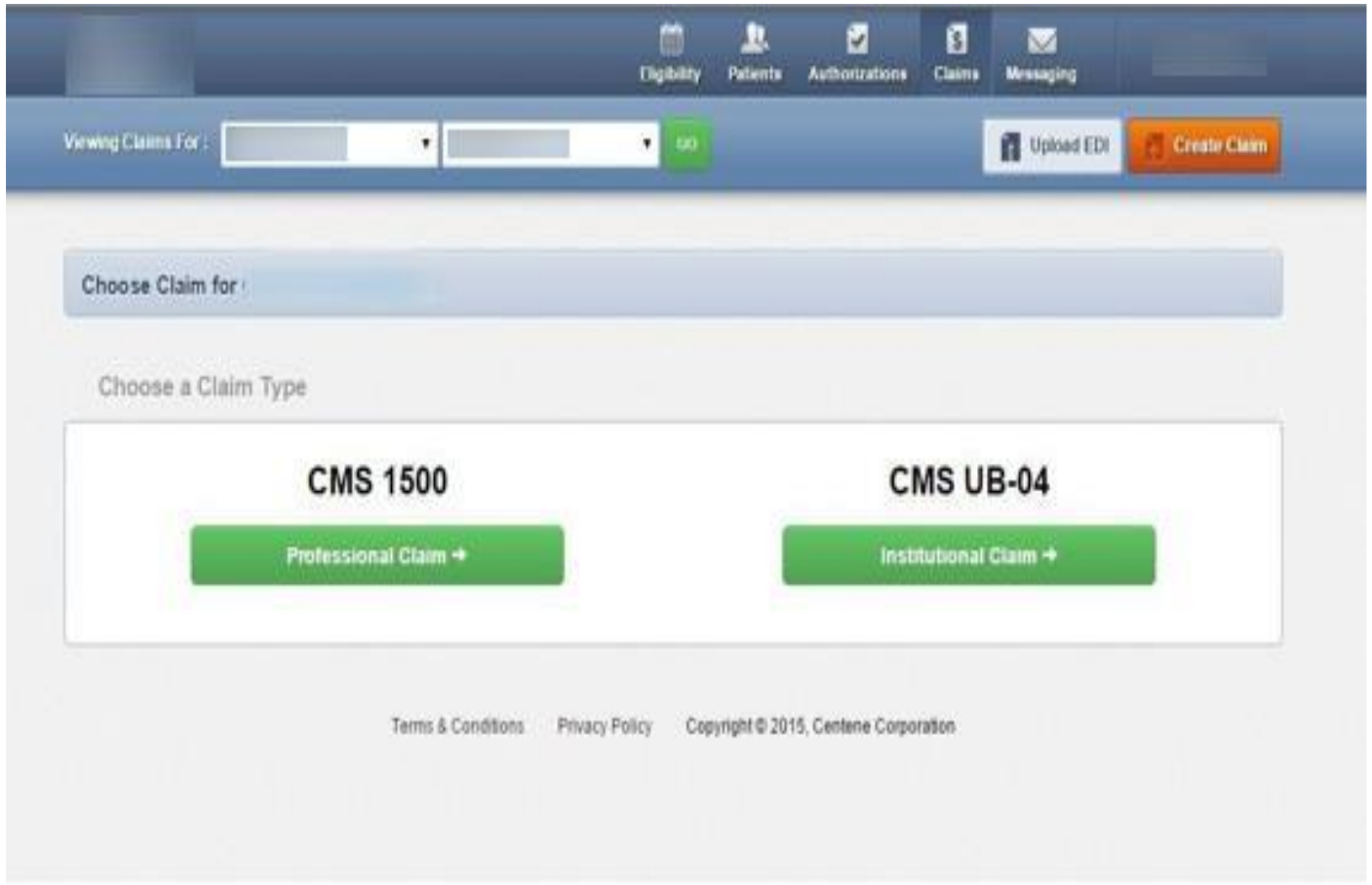
Claims Submissions - Institutional

To submit a new Institutional claim, select the green “Create a New Claim” button within the patient record.



Claims Submissions - Institutional

When prompted, click on the Institutional Claim button.

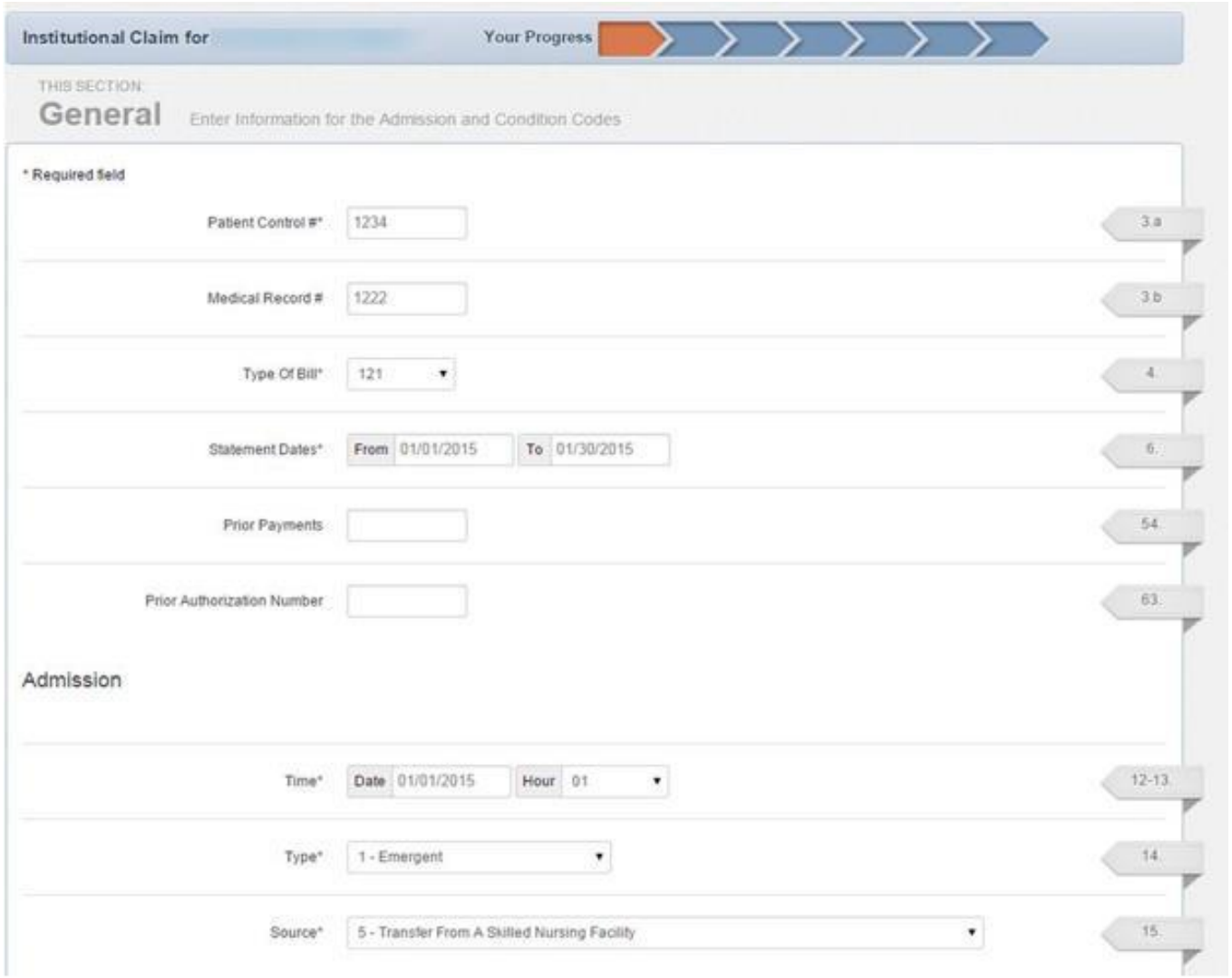


Claims Submissions - Institutional

In the General section, populate the admission and condition code information. The fields displayed here reflect those on a UB-04 form.

Then click Next, and follow the prompts to reflect the Billing Provider, Pay-to Provider, and Attending Provider, etc, and then click Next.

Note that the number along the right represent the box number on the paper claim.



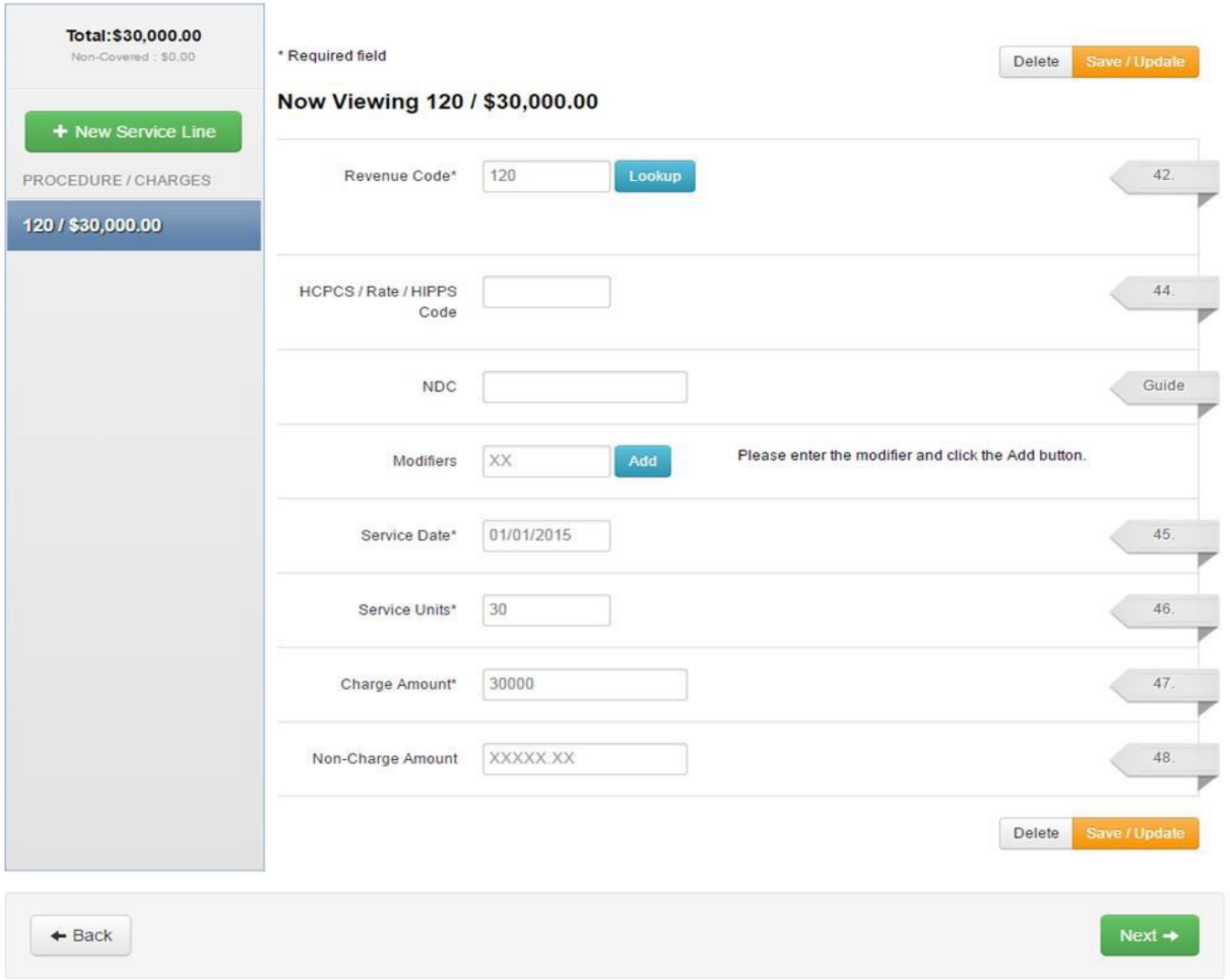
Claims Submissions - Institutional

In the Service Lines section, enter the information about the services provided.

Click **Save/Update**, and to add a new service line

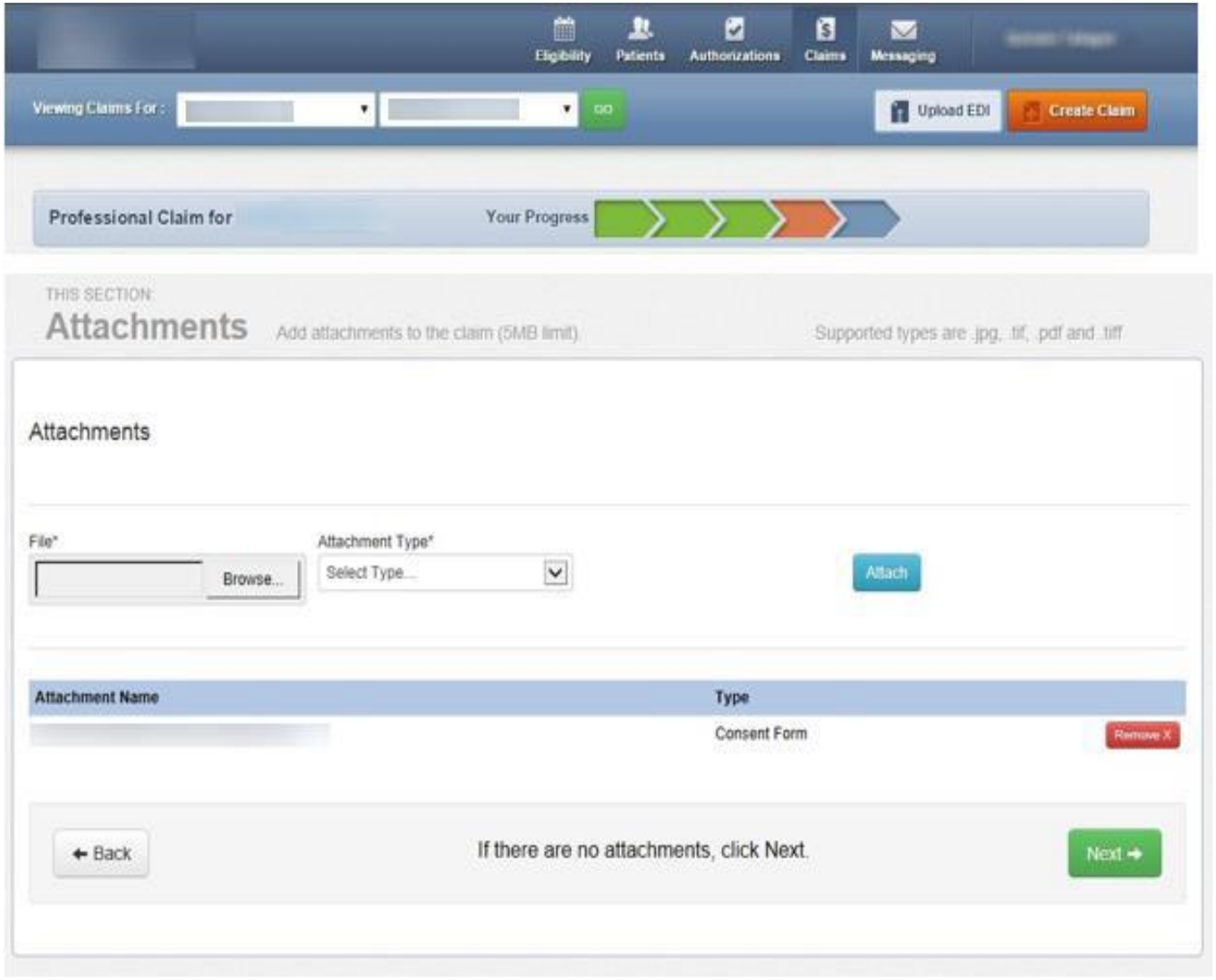
Click the **+ New Service Line** button on the left to add additional service lines.

Click the **Next** button.



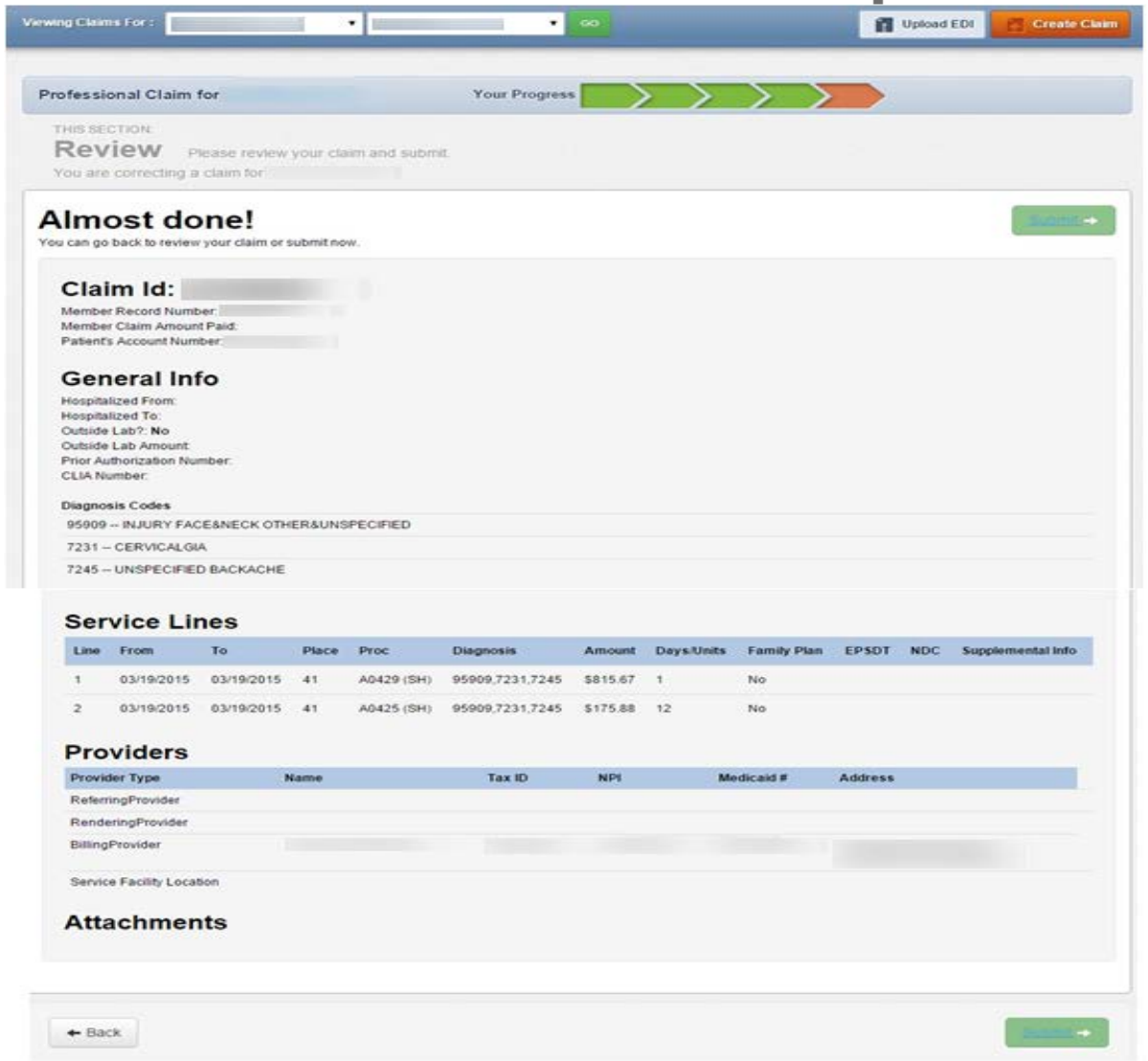
Claims Submissions - Institutional

If you have medical records or other documentation that needs to be attached to the claim, submit it using the Attachments screen. You may use the Browse button to attached any documents pertinent to the claim. If you have no attachments, you may skip this section.



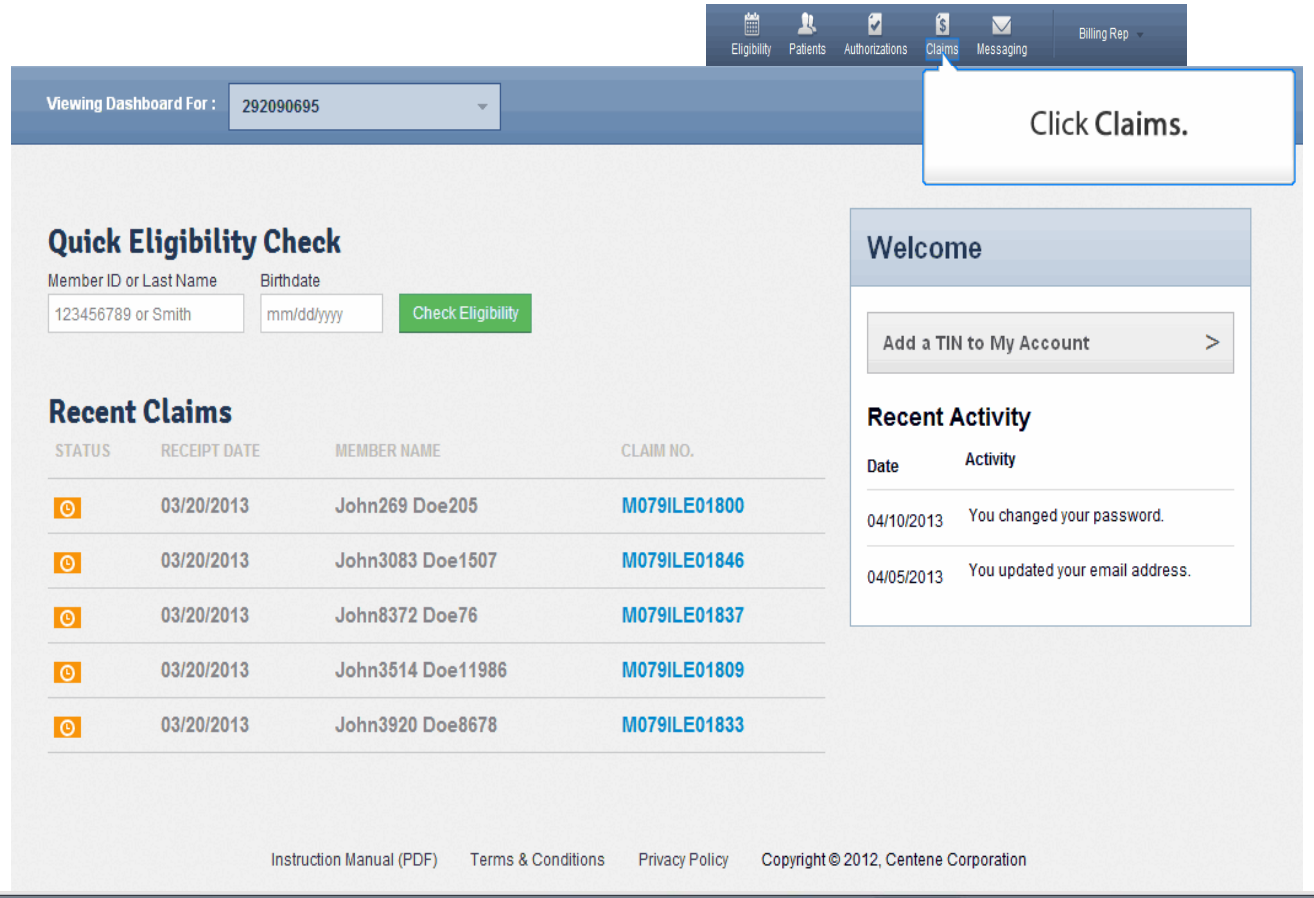
Claims Submissions - Institutional

Your final step is to review the entire claim. Once you have confirmed that everything is correct, click the green Submit button in the bottom, right-hand corner.



Claims Submissions – Batch Claims

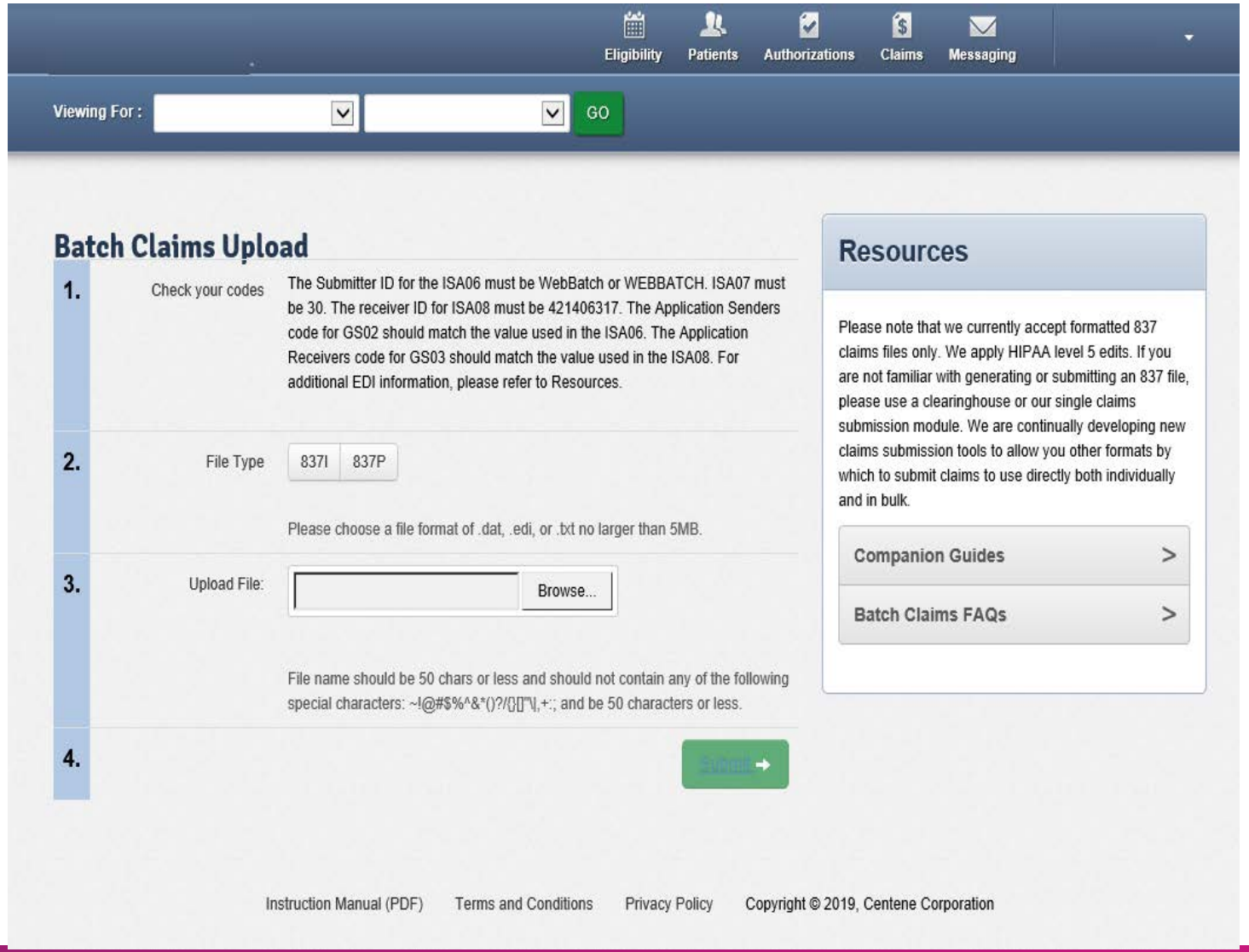
Batch claims can be submitted through the portal by selecting the **Claims** tab at the top of the home page.



On the claims landing page, select **Upload EDI**.

Claims Submissions – Batch Claims

Once on the Batch Claims Upload screen, follow the instructions. There is a Companion Guide and FAQ included if you have any questions.



Carolina Complete Health

Cultural Competency/
Fraud, Waste and Abuse

Cultural Competency

Cultural Competency is the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population. It is the use of a systems perspective which values differences and is responsive to diversity at all levels in an organization. Cultural Competency is developmental, community focused, and family oriented.

Carolina Complete Health:

- Covers benefits for risk factors common among ethnic groups
- Will ensure compliance with the following statues and regulations to ensure eligible beneficiaries have equal access to quality health care regardless of their race, color, creed, sex, national origin, religion, disability, or age : Title VI of the Civil Rights Act of 1964 (which prohibits discrimination on the basis of race, color and national origin); Section 504 of the Rehabilitation Act of 1973 (which prohibits discrimination on the basis of disability); and The Age discrimination of 1975 (which prohibits discrimination on the basis of age).
- Offers a choice of providers with cultural and linguistic expertise
- Expects the provider to be knowledgeable about beneficiary's cultural values and incorporate this information in their treatment plan
- Expects the provider to ask questions relevant to how the family cultural values might influence how the beneficiary handles their diagnosis

Cultural Competency

Carolina Complete Health uses the National Culturally and Linguistically Appropriate Services (CLAS) standards from the Office of Minority Health to guide our efforts to be more culturally competent. Below are a few standards to guide you.

- Principal Standard:
  - Provide effective, equitable , understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs
- Communication and Language Assistance:
  - Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost, to facilitate timely access to all health care and services
- Engagement, Continuous Improvement and Accountability
  - Establish culturally and linguistically appropriate goals, policies and management accountabilities and infuse them throughout the organization's planning and operations.

Cultural Competency

Resources for your Practice:

- Complimentary Interpretation Services
  - As a CCH provider, you have access to interpretation services. To obtain access to a telephonic interpreter please call Provider Services at 1-833-552-3876 and have the beneficiary's ID number present.
  - All customer service phone lines will be TTY and TDD capable for different languages and the deaf
  - CCH material is available minimally in English and Spanish
  - For assistance with Cultural Competency issues and/or educational sessions, please contact Provider Services at the number above or discuss with you Provider Engagement Specialist

Cultural Competency

- Health Literacy—capacity to obtain, process and understand basic health information and services needed to make appropriate decisions. A patient's level of health literacy can impact how and when they take their medication, their understanding of their health conditions, attendance at their appointments and the choices they make regarding treatment. Low health literacy has been linked to poor health outcomes such as higher rates of hospitalization and less use of preventative services.
- What can you do??
  - Slow down—sometimes all you need to do is take a little extra time so that patient can process the information better
  - Use Plain, Nonmedical language—use words like "high blood pressure" instead of "hypertension" or "skin doctor" instead of "dermatologist"
  - Show or Draw Pictures—Visual images can improve the patient's recall of ideas
  - Limit the Amount of Information and Repeat It—Sometimes it can be overwhelming to receive too much information all at once
  - Use the "Teach-Back" method—Confirm that the patient understands by asking them to repeat back your instructions.
  - Create a Shame-free Environment that Encourages Questions—make patients feel comfortable asking questions. Use the patient's family or friends in promoting understanding

Fraud, Waste and Abuse

Carolina Complete Health 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
- Detecting waste through data analytics and medical records review
- Reporting abuse 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 and abuse by applying fair and firm enforcement policies such as a pre-payment review and a retrospective review, as well as developing and implementing a corrective action plan

Fraud, Waste and Abuse

CCH performs front and back end audits to ensure compliance with billing regulations.

Most Common Issues:

- Use of incorrect billing code
- Not following the service authorization
- Inaccurate procedure codes for the provided service
- Excessive use of units not authorized by the care coordinator
- Lending of insurance card

Benefits of Eliminating Fraud, Waste and Abuse:

- Improves patient care
- Saves dollars and identifies recoupments
- Decreases wasteful medical expenses

Fraud, Waste and Abuse

- Potential Fraud, Waste or Abuse reporting may be reported on Carolina Complete Health anonymous and confidential hotline at **1-800-XXX-XXXX;** by contacting our Compliance Officer at **XXX-XXX-XXXX.**

Fraud, Waste and Abuse

- To report potential Fraud, Waste or Abuse directly to the North Carolina DHHS, please use one of the methods below:
  - Phone 1-800-XXX-XXXX or for reports on Medicaid providers XXX-XXX-XXXX
  - Email: https://xxxxxxxxxxxxxxxxxx
  - Or write to:

    Xxxxxxxxxxxxx

    Xxxxxxxxxxxxxxxx

    Xxxxxxxxxxxxxxxx

    Xxxxxxxxxxxxxxxxx

    xxxxxxxxxxxxxxxxx

Evaluation of Course

- Please take the time to evaluate this course and add any comments you may have.
- We value your feedback. We will tabulate responses and comments. These summaries will be used in the formation of future courses on any specific topic that our participating providers find beneficial
- Future courses may be held regionally, face-to-face, or via webinars. Our intent is to keep all of you informed as much as possible

Phone Number:

XXX-XXX-XXXX

TDD/TTY: 771—Not sure this accurate check #

Website:

www.carolinacompletehealth.com

Copies of training and educational materials can be requested by calling the Provider Services number (xxx-xxx-xxxx) or your assigned provider representative.

Carolina Complete Health

Better Health Outcomes, Lower Costs.™

QUESTIONS????