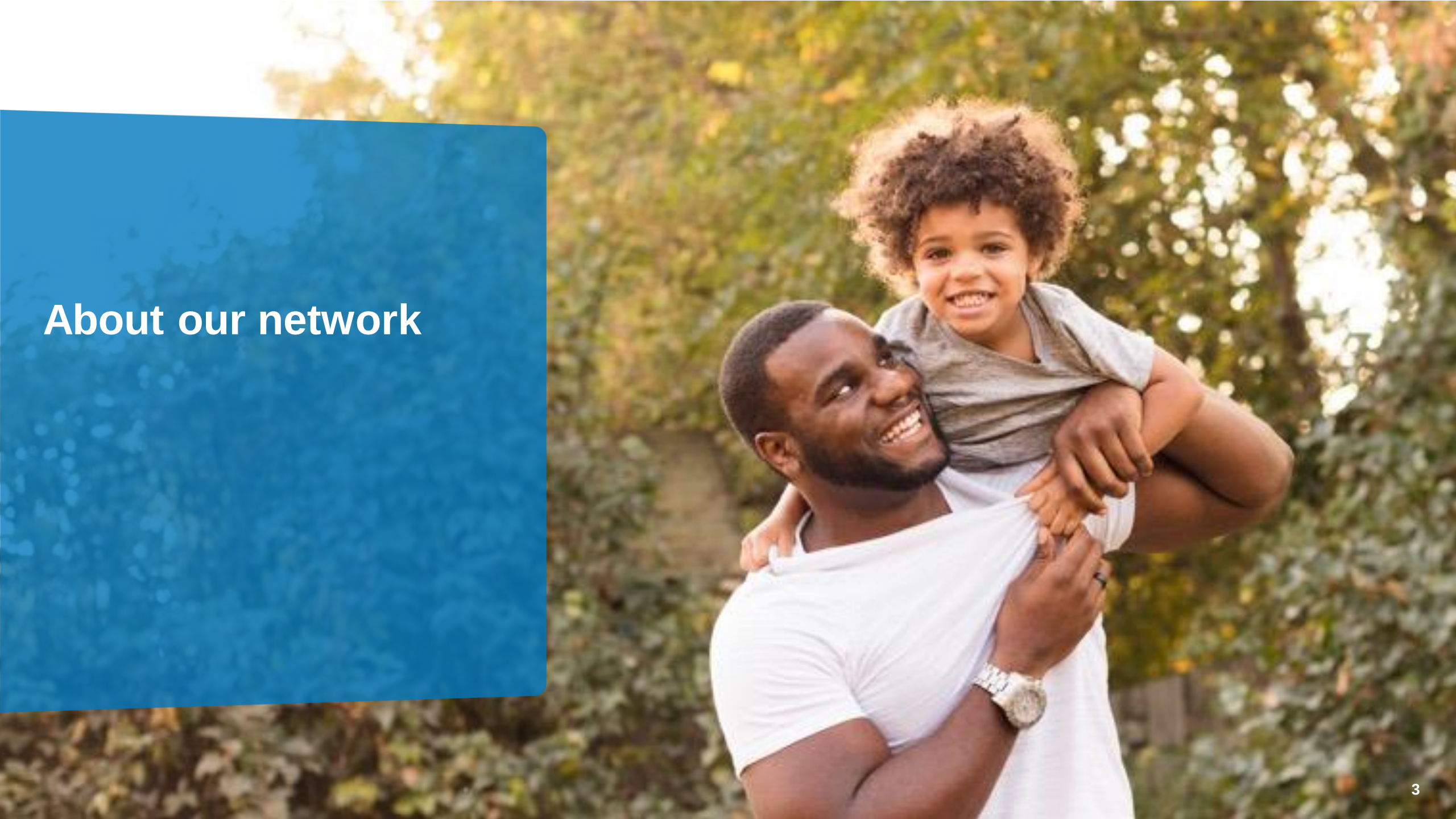
Anthem Blue Cross and Blue Shield (Anthem) provider orientation

Ohio Medicaid Managed Care (OMMC)

Agenda

- About our network
- Understanding and supporting our members
- Working with Anthem
- Staying connected

About our network



About our network

- OMMC
- The Next Generation program
- Partnering to win
- How to join our network

OMMC

- Anthem
- OMMC
- The Next Generation Program

Anthem in Ohio

- As one of the nation's leading health plans, Anthem has invested the time and resources necessary to fully understand and serve millions of members in state-sponsored programs across the country.
- Anthem already proudly serves individuals in Ohio with its commercial product. The Medicaid plan aligns with 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.
  - On go-live, Anthem will become a new statewide Medicaid plan, supporting members in all of Ohio's 88 counties.
  - Our new plan is part of ODM's Next Generation program for OMMC.

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 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 (provider network management website):
  - October 1, 2022
    - (**Note:** This does not replace the credentialing and recredentialing process for Anthem for Medicare or Commercial lines of business.)

Next Generation program cont.

- **On February 1, 2023**, ODM will launch the Next Generation managed care plans and program requirements, including exciting improvements that will support members in accessing the healthcare services and supports they need. Also implemented will be the new Electronic Data Interchange (EDI), increasing transparency and visibility of member care and services.

- **Subsequently**, ODM will fully launch OMES modules to provide streamlined processes for claims, prior authorizations, and other administrative tasks for providers.

Partnering to win

- OhioRISE
- Community-based organizations
- Education
- Telehealth

OhioRISE

- OhioRISE is a specialized managed care program for youth with complex behavioral health and multisystem needs:
  - ODM selected Aetna Better Health of Ohio to serve as the new OhioRISE specialized MCO.
  - OhioRISE members and families will 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 Anthem managed care enrollment for their physical health, and Anthem will be included in their care management.
- To be eligible for OhioRISE, an individual must:
  - Be enrolled in Ohio Medicaid, either managed care or fee-for-service.
  - Be under the age of 21.
  - Meet a functional needs threshold for behavioral health care, as identified by the *Child and Adolescent Needs and Strengths* (*CANS*) assessment tool or by use of an inpatient behavioral health service.

Community-based organizations

- **Motivo:** Increasing access to mental health services in order to increase the workforce and accelerate access to mental health services in rural Ohio
- **OhioDRIVE:** A collaboration between Anthem's Transportation team and other organizations to address innovative solutions to transportation challenges
- **Expanding mobile clinic capacity:** Anthem will work with select providers to provide mobile clinic services as part of our overall relationship, and to increase the frequency of visits and the number of counties they serve

Educational opportunities

Our members' success is important to us, and we know success is dependent on many factors — education being one of them. Therefore, we will devote resources to development through:

- Investing in the future of Ohio rural and urban providers.
  - Anthem is committed to investing in provider workforce development.
- Industry certification assistance.
  - Anthem will cover the costs of obtaining industry certification in early childhood education, foundations of reading, business education, computer science, technology education, English language arts, health, and marketing.

Telehealth

Expanding telehealth capabilities:

- We will bring our robust suite of telehealth and digital solutions to providers where needed to support their efforts to expand access to care to their patients. These include our:
  - Virtual practice telehealth platform Digital technology solutions to expand access points through TytoCare and iPad technology
  - Virtual solutions that enable:
    - Integrated behavioral health(Bright Heart Health)
    - Specialty consultations (ConferMED eConsults)
    - Virtual learning for providers (Project Extension for Community Healthcare Outcomes®).
- We will also offer our LiveHealth Online and Telehealth Member Kits, which include tools for members to encourage self-monitoring and increase the effectiveness of telehealth visits.
- Visit https://providers.anthem.com/oh, navigate to the *Provider* section on the top right and select **Telehealth** to learn more about these resources and how to access them.

Joining our network

- Enrolling in OMMC
- Getting credentialed
- Contracting information

Enrollment

- **Get enrolled with OMMC:**
  - To become an OMMC provider, simply complete a web-based application. The web-based provider application is available on the OMMC site and is designed to walk you through the steps to submit all the information the OMMC program needs to enroll you as a new provider. (**Note:** Ohio does not accept paper applications.)
- **Get credentialed:**
  - Effective October 1, 2022, all provider enrollment applications must be submitted using Ohio Medicaid's new Provider Network Management (PNM) website. The PNM website will be 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 **https://ohpnm.omes.maximus.com/OH_PNM_PROD/Account/Login.aspx**
- **Get contracted:**
  - Go to the Anthem provider website and select *Join Our Network*:
  - **JON_OH.pdf (anthem.com)**

About our network — review

- OMMC
- The Next Generation program
- Partnering to win
- How to join our network

Understanding and supporting our members

Understanding and supporting our members

- Eligibility
- Benefits and services
- Patient care
- Health information exchange (HIE)
- Electronic visit verification (EVV)

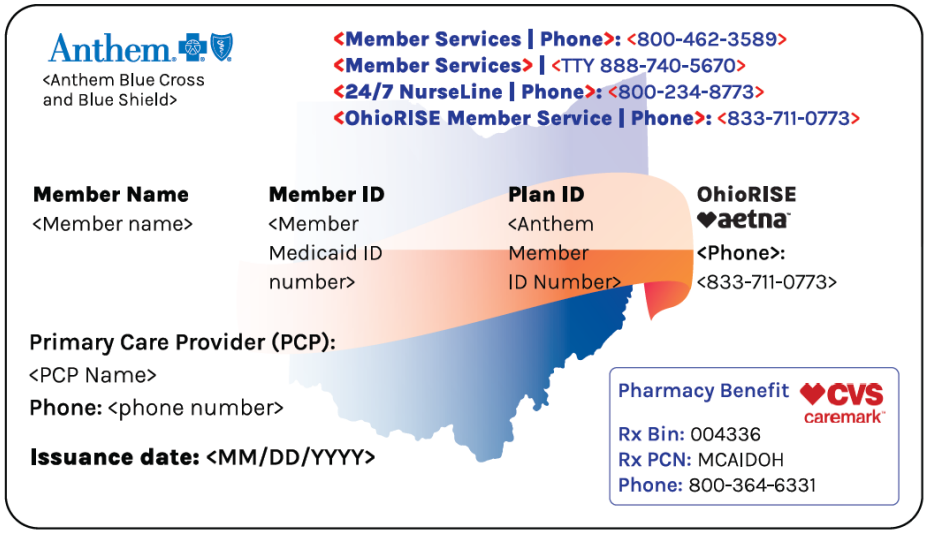
Eligibility

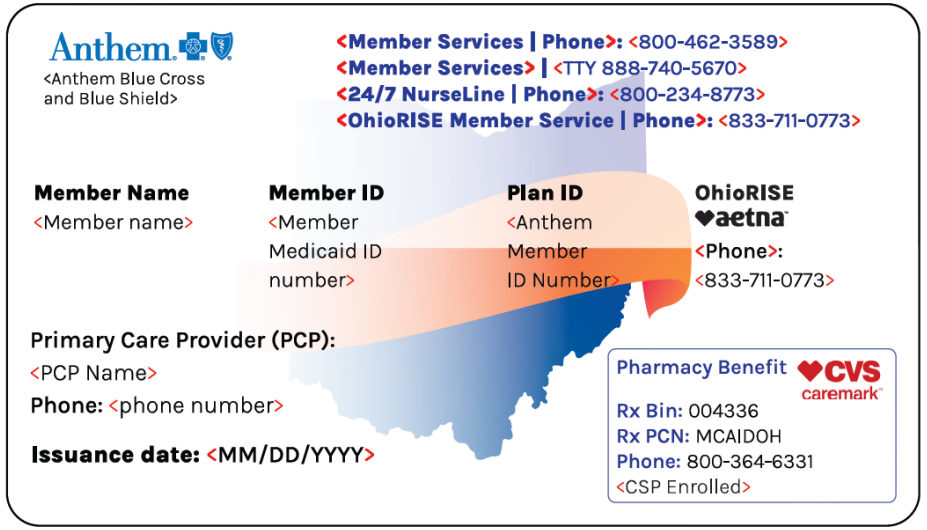
- Member ID cards
- Determining eligibility
- Choosing a PCP

Member ID cards

Individuals enrolled with Anthem for Medicaid will receive Medicaid ID cards and have access to an electronic member ID card through the Sydney app.

Note: Unlike the Commercial and Medicare ID cards Ohio providers are accustomed to, the Ohio Medicaid cards will **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:
    - **www.Availity.com**
- Providers who do not have a relationship with an established ODM trading partner can check eligibility by:
  - Availity Essentials
    - **www.Availity.com**

Choosing a PCP

- At Anthem, 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.

Benefits and services

- Covered benefits and services
- Value-added services
- Behavioral health covered services
- Vision and dental services
- Nonemergent transportation

Covered benefits and services

In addition to providing the full range of required and contracted core benefits and services, Anthem Blue Cross and Blue Shield may choose to provide in lieu of services (ILOS) upon prior approval by the Ohio Department of Medicaid. This provision allows use of medically appropriate services that are not covered under the state-specific benefit package on a case-by-case basis.

Value-added services

- Value-added services give Anthem 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.

- Our 14 value-added services, including baby and transportation essentials, reflect the specific needs and critical social drivers of health impacting (SDOH) our local communities.

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 CANS* assessment

Behavioral health covered services (cont.)

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

Vision and dental services

- **Dental services:**
  - Routine dental care is covered for qualifying members by Anthem through DentaQuest.
- **Vision services:**
  - Anthem contracts with EyeMed* to provide covered routine vision services. Anthem covers the following services when performed by a EyeMed-contracted provider:
    - Routine vision services
    - Eyeglasses
  - To arrange for vision services, call EyeMed at **877-658-1801**.

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

Nonemergent transportation

- Nonemergent transportation is a benefit provided to Anthem 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 Anthem members in wheelchairs:
  - Routine rides must be scheduled at least two business days prior to the healthcare appointment.
  - Same day rides can be scheduled within three hours if there is an an urgent need.
- Anthem 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 **888-644-3547** to schedule rides.

Patient care

- Cultural competency
- Elevate | 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 culture 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 competency (cont.)

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.

MyDiversePatients

- 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 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.

Elevate | Population Health

Our population health model, Elevate | Population Health, reflects the top health priorities in Ohio. Within the Elevate | Population Health model, Anthem has identified four focus areas that align with ODM's goals and vision:

- Maternity
- Care coordination
- Behavioral health and substance use disorder (SUD)
- Health equity and SDOH

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

- Anthem's Care Management program is a collaborative effort that gives assistance to 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 to provide feedback on our members' care plans.
- Care Management phone: **844-441-1505**
- Care Management fax: **877-881-1831**

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℠, 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 or visit My Advocate* at https://www.myadvocatehelps.com.

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**.

ODM’s NurtureOhio program

Anthem encourages 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 https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/special-programs-and-initiatives/praf/praf.

For non-OB Providers who need to notify Anthem of a pregnancy, please use the *Report of Pregnancy (ROP)* form, found at the above website as well.

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*.

ODM's NurtureOhio program (cont.)

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

- 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 maternity form does **not** replace the need to enter a PRAF on a pregnant member.

Anthem requires notification of delivery following birth. Please send newborn and birth clinical data to the fiscal intermediary.

Coordination of behavioral health and physical health treatment

- Anthem facilitates 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:
  - Anthem’s 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, 7 days/week
Urgent care (includes medical, behavioral health, and dental services)	24 hours, 7 days/week within 48 hours of request
Behavioral health nonlife-threatening emergency	Within 6 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, 7 days/week
Primary care appointment	Within 6 weeks
Nonurgent sick primary care	Within 3 calendar days

Access and availability standards (cont.)

Type of visit	Minimum standard
Prenatal care — first or second trimester	First appointment. within 7 calendar days; follow-up appointments no more than 14 calendar days after request
Prenatal care — third trimester or high-risk pregnancy	Within 3 calendar days
Specialty care appointment	Within 6 weeks
Dental appointment	Within 6 weeks of request

Access and availability standards (cont.)

- Services for members under 21 years of age:
  - Anthem strongly recommends that 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 Anthem members enrolled in Medicaid. The statement must include the following:
    - Waiting times for appointments
    - Waiting times for care at facilities
    - Languages spoken

Healthchek — EPSDT services

- EPSDT is Medicaid's federally mandated, comprehensive, and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the *Omnibus Budget Reconciliation Act of 1989* and requires states to cover all services within the scope of the federal Medicaid program. The intent of the EPSDT program is to focus attention on early prevention and treatment. Requirements include periodic screening, vision, dental, and hearing services.
- Services include:
  - Screening.
  - Diagnosis and treatment.
  - Transportation and scheduling assistance.

Healthchek — EPSDT services (cont.)

- Screening must 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.
- Anthem reviews 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

- Anthem is committed to ensuring members receive EPSDT/Healthchek services.
- Anthem delivers 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
  - Each calendar year for members from age 4 to under 21
  - When the member is identified as pregnant, regardless of the member's age
- Anthem encourages 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)
- HIE
- EVV

Integration and data flow for pharmacy (SPBM)

- The SPBM is a specialized managed care program operating as a prepaid ambulatory health plan that will provide pharmacy benefits for the entire Medicaid Managed Care population (excluding MyCare members).
- The SPBM will work 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 will reduce 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.

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.
- Anthem will require all our Medicaid network hospitals to provide admission, discharge, and transfer (ADT) data to both Ohio HIEs, thereby further expanding our access to ADT data for our Medicaid members. Anthem will share this information with our OhioRISE and SPBM partners in real time.
- Ohio HIEs:
  - CliniSync
  - The Health Collaborative
- Anthem plans to work closely with both the HIEs in Ohio to close the referral loops for SDOH.
- Anthem 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.)

Anthem 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
- Any and all codes that are in your electronic medical record system will be included in the data exchange to Anthem
- 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

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

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 https://medicaid.ohio.gov/resources-for-providers/special-programs-and-initiatives/electronic-visit-verification.

Understanding and supporting our members — review

- Eligibility
- Benefits and services
- Patient care
- HIE
- EVV

Working with Anthem

Working with Anthem

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

Claims and billing

- Submitting claims
- Claim status inquiries
- Return claims
- EDI
- EFT-ERA
- Overpayments
- Claims reconsideration and appeals/disputes
- 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
- Anthem payer ID: 0002937:
  - Link to ODM TP website:
    - **https://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:
  - **www.Availity.com**

Submitting claims (cont.)

- Timely filing requirements: Filing limits are determined as follows:
  - If Anthem is the primary payer, the time period is 365 days from the date of service or date of discharge on the claim unless stated differently in your contract.
  - If the member has other health insurance that is primary, timely filing is 180 days from the date of the explanation of payment of the other carrier.

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 post-payment) 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.

Electronic submissions (EDI)

- Providers who have an established ODM trading partner will begin submitting their claims to ODM via the FI starting February 1, 2023. For those providers virtually all EDI transactions will flow thru the FI and on to the appropriate Medicaid MCE:
  - Anthem EDI payer ID: 0002937 — ODM
- 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)

Checking claim status

- Providers can check claim status via the following methods:
  - Accessing ODM's fiscal intermediary website for providers.
  - Checking the claim status on Availity Essentials at www.availity.com. Select **Login** or **Register** to access the secure site. From the Availity homepage, select Claims & Payments > Claims Status.
  - Watch for and confirm plan electronic reports from your vendor/clearinghouse or, if you are using Availity as your clearinghouse, view reports under *EDI Clearinghouse/Send and Receive Files* to ensure your claims have been accepted by Anthem.
  - Calling Provider Services at **844-912-1226 (operational once we are a live plan).**
  - ODM Integrated Help Desk at **800-686-1516**.

Returned claims

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

Anthem 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
- 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 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 Ohio Medicaid plan.
  - Please work with your vendor or clearinghouse to enroll your 835s with ODM.
  - Use the **link** to submit your 835 registration to ODM.

Note: Commercial policies with Anthem will continue to be registered and managed by Availity.

Claims overpayment recovery and refund procedure

- Anthem seeks recovery of all excess claim payments from the person or entity to whom the benefit check was made payable. When an overpayment is discovered, Anthem initiates the overpayment recovery process by sending written notification.
- If you are notified by Anthem 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

  P.O. Box 62500

  Virginia Beach, Virginia 23466-2500
- The *Recoupment Notification Form* and the *Overpayment Refund Notification Form* are located on our provider site at https://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 Anthem notifies a provider of an overpayment, Anthem 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 (operational once we are a live plan)**
  - For claims re-evaluation, send your correspondence to the address indicated on the overpayment notice. If Anthem does not hear from you or receive payment within 60 days, the overpayment amount will be deducted from your future claim payments.

Claim payment — reconsideration and dispute process

- Claim payment reconsideration:
  - The initial request for an investigation into the outcome of the claim
  - Most issues are resolved during the reconsideration process
  - If a provider is dissatisfied with the outcome of a reconsideration determination, the provider may submit a claim payment dispute.
- Claim payment dispute:
  - If the reconsideration did not resolve the issue, a more through analysis will occur utilizing all applicable statutory, regulatory, contractual, and subcontract provisions; Anthem 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 — reconsideration and dispute process (cont.)

- The provider or the provider's authorized representative may submit a claim payment reconsideration or appeal in one of three ways:
  - **Website request:** Use the Provider Availity Payment Dispute Tool at www.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

    Provider Payment Disputes

    Payment dispute unit

    P.O. Box 62500

    Virginia Beach, VA 23466-1599
  - **Verbal request:** Call Provider Services at **844-912-1226** (operational once we are a live plan)

Monday through Friday, from 8 a.m. to 5 p.m.

Note: If you need to include supporting documentation (for example, *EOB*, *Consent Form*, medical records, etc.) do not use this option.

Claim payment — reconsideration and dispute process (cont.)

- The request should include:
  - Your name, address, phone number, email, and either your NPI number or TIN.
  - The member’s name and his or her Anthem ID number.
  - A list of disputed claims, including the Anthem 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 Anthem 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 Anthem pays 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.

Authorizations

- *Medical Policies*
- *Clinical Utilization Management Guidelines*
- Prior authorization submission
- Checking authorization status
- Prior authorization lookup tool
- Authorization review time frames
- Peer-to-peer consultations

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*, Anthem *Medical Policies*, and Anthem *Clinical Utilization Management Guidelines*/IngenioRx* 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.

Prior authorization

- To request prior authorization providers can submit through 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) – Pre-cert for elective admissions and OP surgeries

- **Outpatient authorization fax numbers:**
  - **877-643-0672** (Physical health) – HHC, high dollar imagine, 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) – pre-cert 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 inpatient status.

Prior authorization status

- Prior authorization is required on inpatient and post-acute requests whether in-network or out-of network. To determine which services require prior authorization providers should refer to the precertification look up tool: **https://providers.anthem.com/oh**.
- You can check the status of an authorization by using the Interactive Care Reviewer located within Availity.

Note: Prior authorizations approved by another MCO prior to go-live will be honored until the authorization expires.

Precertification lookup tool

- Anthem's Precertification Lookup Tool:
  - Requirements for outpatient services can be viewed via the Precertification Lookup Tool at **https://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.

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
  - For retrospective reviews: within 30 calendar days of request
- Emergency medical services:
  - Anthem does 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, 7 days a week. If the emergency room visit results in the member's admission to the hospital, providers must contact Anthem within 48 hours.

Authorization review time frames (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.

Peer-to-peer consultations

- **Peer-to-peer consultations:**
  - If you disagree with a decision and want to discuss the decision with the physician reviewer, call the Behavioral Health department at **844-441-1506** or the Medical Management department at **833-308-3035.** If you request a peer-to-peer discussion, Anthem will, within 24 hours of your request, acknowledge your request and offer a peer-to-peer conversation within a mutually agreed upon time

Grievances and appeals

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

Member appeals – preservice authorization denials

- If an authorization is denied prior to the service being rendered to the member, either the member or the provider on behalf of a member can submit a member appeal. This appeal type requires the members written consent.
- Member medical necessity/authorization appeals are to be submitted using the ODM *Standardized Appeal Form*:
  - The *Standardized Appeal Form* can find the form on the:
    - ODM website at **https://medicaid.ohio.gov/wps/portal/gov/medicaid/stakeholders-and-partners/legal-and-contracts/forms/forms**
    - Anthem provider website at https://providers.anthem.com/oh.
    - **Note:** The form will also be attached to the *Notice of Action*.
- Appeals can be submitted via Availity Online (provider website at https://providers.anthem.com/oh. Select **Login** or **Register** to access the secure site:
  - Faxed directly to the Appeals department at **866-587-3316**
  - Email the completed appeal form to ohioga@anthem.com
  - By phone to Provider Services at **844-912-1226**, Monday through Friday, 7 a.m. to 8 p.m. ET
  - Mail: Anthem Blue Cross and Blue Shield
    Central Appeals Processing
    P.O. Box 62500
    Virginia Beach, VA 23466-2500
  - Members can also submit directly via the secure member website or mobile application

Member Appeal decisions – preservice authorization denials (cont.)

- **Appeals decided in favor of the member:**
  - Written notice of the appeal's resolution will be sent to the member and authorized representative.
  - The notice will include the resolution decision and the date of resolution at a minimum.
  - Anthem will update the authorization no later than 72 hours from the appeal resolution.
- **Appeal resolutions not resolved wholly in the member's favor:**
  - Written notification of the appeal's resolution will be sent to the member and authorized representative. Written resolution notice will also include:
    - The right to request a state hearing and how to request a state hearing, with attached ODM forms.
    - The right to continue to receive benefits pending a state hearing and how to request to request continuation of benefits.
    - That the member may be liable for the costs of any continued benefits if the managed care plan's adverse benefit determination is upheld at the state hearing.

Member Appeal – preservice authorization denials timelines

- Anthem will send written acknowledgment of receipt of the appeals to the member and their representatives within three business days of receipt of the appeal.
- Standard appeals will be reviewed and resolved within 15 calendar days of the receipt of the appeal unless an extension is approved.
- Expedited appeals will be reviewed and resolved within 72 hours from receipt of the appeal unless an extension of timeframe is approved. Expedited appeals affecting a member's health should be faxed directly to the appeals department at **866-587-3316**.
- Anthem shall determine within one business day whether to expedite an appeal request and notify member and provider within one business day of an appeal that meets the criteria for expedited resolution.
- If the member or provider filing with members consent does not agree with the appeal decision, the member can request a State Fair Hearing (see State Fair Hearing process).

Provider – 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 Anthem, not requiring the member consent.
- Provider appeals can be submitted the following ways:
  - Electronically: Using Availity Essentials at **Availity.com**
  - Fax: Directly to the appeals department at **866-587-3316**
- Appeals must be submitted within 30 calendar days from initial determination. Anthem will send written acknowledgment of the appeal to the member and their representatives within three business days of receipt.
- Anthem will issue a decision within 10 calendar days for non-urgent 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/retrospective authorizations

- If services have been rendered to the member, providers should file the claim with medical records along with any extenuating circumstances for not submitting the prior authorization, so a medical necessity review will be completed.
- If a provider is dissatisfied with the outcome of an initial medical necessity review done as part of the claim submission, they can file an appeal.
- Provider authorization/UM appeals can be submitted the following ways:
  - Electronically: Using Availity Essentials at **Availity.com**
  - Fax: Directly to the appeals department at **866-587-3316**
  - Appeals must be submitted within 30 calendar days from initial denial. Anthem will send written acknowledgment of the appeal to the provider within three business days of receipt.
  - Anthem will respond to Appeals associated with a claim denial within 30 days.
  - Providers who do not agree with a post service retrospective review can request and external medical review. (See EMR Process)

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 Anthem's 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 Ohio Medicaid MCE External Review Request form located at **www.hmspermedion.com**
- Providers need to upload the request form and all supporting documentation to Permedion's provider portal located at **https://ecenter.hmsy.com** (new users will send their documentation through secured email at IMR@gainwelltechnologies.com to establish portal 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 the Anthem appeals process before requesting a state hearing.
- If Anthem fails 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 Anthem.
- 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:
  - Anthem 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 Anthem, 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.
- Anthem will receive these complaints directly, in real time, from ODM and has 15 business days to respond to the provider with a resolution. Providers are encouraged to utilize 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: https://providercomplaints.ohiomh.com/ComplaintForm.aspx?forceredirect=true
  - Anthem provider website at https://providers.anthem.com/oh.

Working with Anthem

- 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 is successful
- **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 www.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 (operational once we are a live plan).**

Reporting fraud, waste, and abuse

- If you suspect a provider (for example, provider group, hospital, doctor, dentist, counselor, medical supply company, etc.) 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 www.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 Anthem —review

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

Staying connected

Staying connected

- Information updates
- Surveys
- Provider websites

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 https://providers.anthem.com/oh.

Note: Provider News emails will come from GBDProviderCommunications@email.anthem.com so add them to your safe sender/recipient list to ensure you receive our emails.

Updating your business information

It is critical members receive accurate and current data related to provider availability. Providers and facilities must notify ODM's PNM, which acts as ODM's central credentialing website of any demographic changes. 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.

Note: If updates are not submitted 30 days prior to the change, claims submitted for members may be the responsibility of the provider or facility.

Surveys

- Provider satisfaction
- Member satisfaction

Provider satisfaction surveys and administration

- Anthem 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 Anthem's healthcare services is measured every year through the annual 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.
- Anthem customer service.
- Provider communications.
- Provider office staff performance.

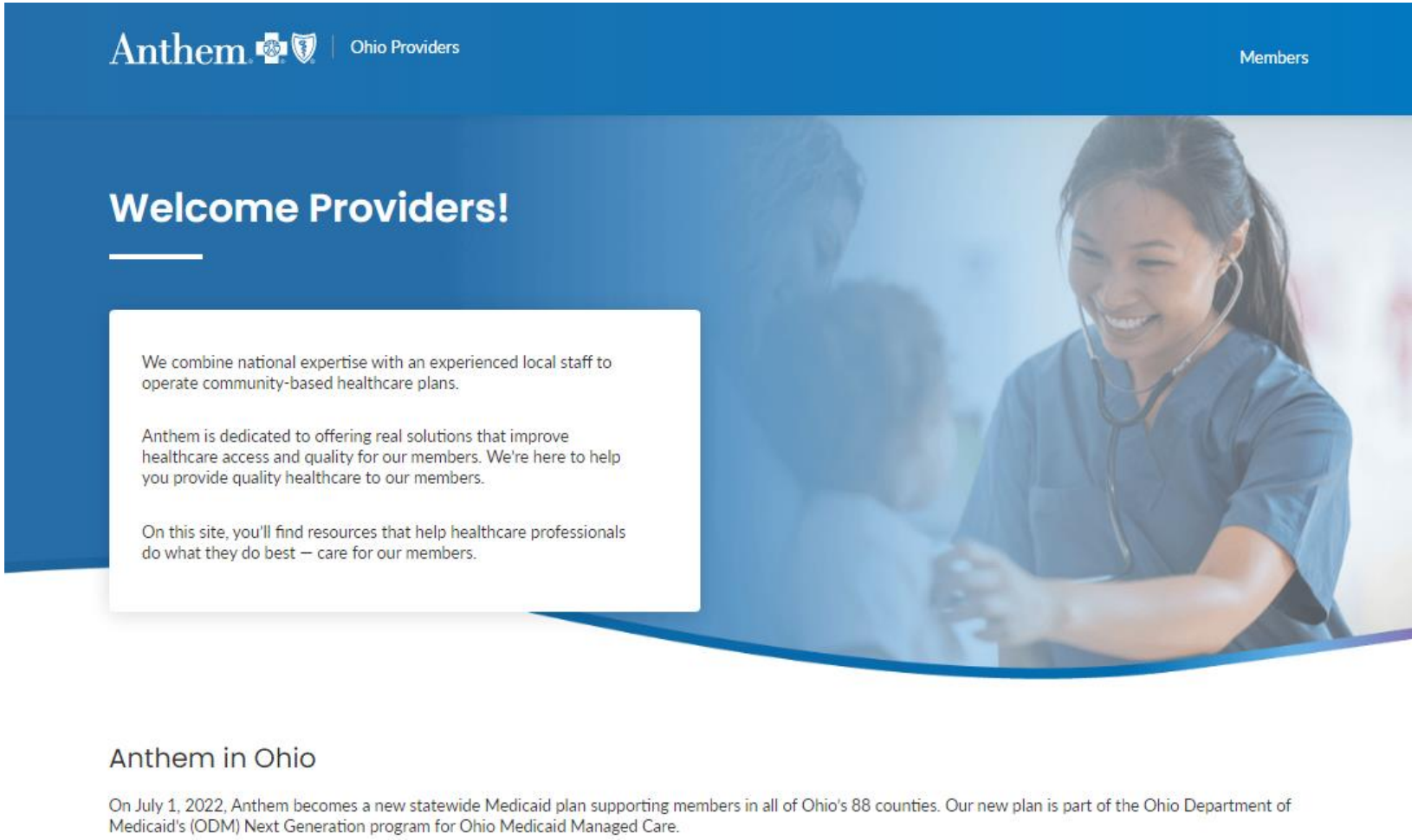
We distribute the results of the CAHPS survey to both members and providers. Providers should review the results, share the results with office staff, and incorporate appropriate changes in their offices.

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Provider websites

- Provider public website
- Provider training academy
- Provider Pathways
- Availity

Anthem provider website



The Anthem provider website is available at https://providers.anthem.com/ohio-provider/welcome.

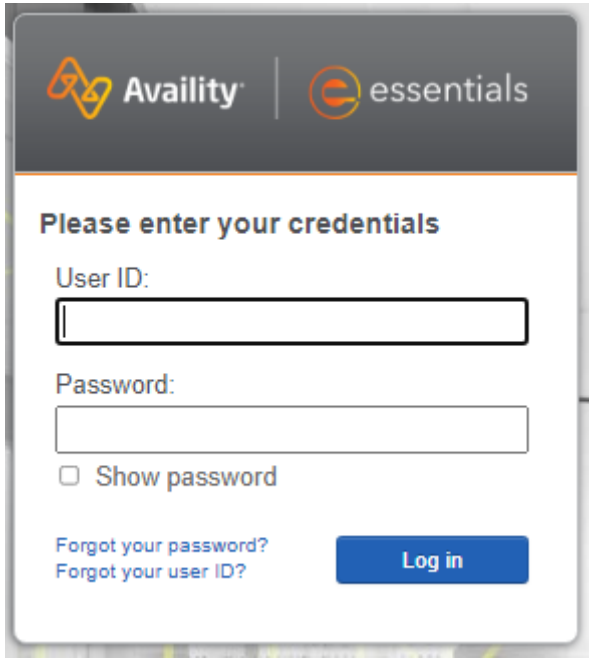
The full site will be launched by go-live.

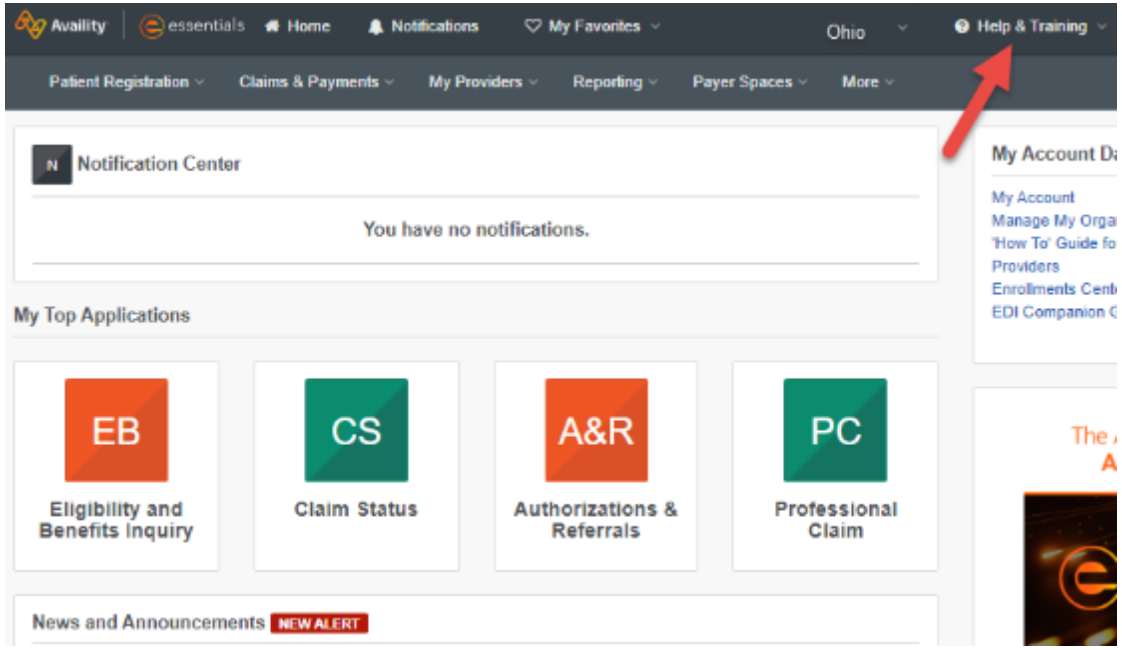
Provider Pathways

- We’re using Provider Pathways to make sharing information about our Anthem tools and resources more useful to you. Provider Pathways is a 24/7 digital resource that provides a foundation for working with.
- This self-paced offering provides an easy, on-demand option for sharing information on our most frequently used provider tools and resources, including:
  - Joining our network.
  - Registering for Availity.
  - Enrolling in EFT or ERA.
  - Checking member eligibility and claim status.
  - Authorizations.
  - Reporting possible fraud and abuse.
- In addition, Provider Pathways’ eLearning gives you the flexibility to schedule training for yourself and your staff.

Availity resources and Custom Learning Center

- Availity (www.availity.com) is a web portal 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.





Staying connected — review

- Information updates
- Surveys
- Provider websites

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: https://providers.anthem.com/oh
- Provider Services: **844-912-1226 (operational once we are a live plan)**
- Please send any questions not covered in this presentation or Frequently Asked Questions to OhioMedicaidProvider@anthem.com.

Addendum – The following slides contain additional information on Consumer Assessment of Healthcare Provider and Systems (CAHPS)

CAHPS

- **What is CAHPS?**
  - 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 (www.patientexptraining.com). For a full CAHPS overview, visit the Provider Training Academy/Provider Education webpage.

CAHPS (cont.)

- **Why focus on patient experience?**
  - 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, so it can affect your reputation
  - Decreased malpractice risk
  - Improving patient experiences can increase employee retention

Additional resource: What Matters Most: Improving the Patient Experience (www.patientexptraining.com)..For a full CAHPS overview, visit the Provider Training Academy/Provider Education webpage.

CAHPS (cont.)

- **How to improve the patient experience?**
  - 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 (www.patientexptraining.com).. For a full CAHPS overview, visit the Provider Training Academy/Provider Education webpage.

*Availity, LLC is an independent company providing administrative support services on behalf of Anthem Blue Cross and Blue Shield. DentaQuest is an independent company providing dental benefit management services on behalf of Anthem Blue Cross and Blue Shield, EyeMed is an independent company providing routine vision services on behalf of Anthem Blue Cross and Blue Shield. Access2Care is an independent company providing nonemergent transportation services on behalf of Anthem Blue Cross and Blue Shield. Change Healthcare is an independent company managing the My Advocate program on behalf of Anthem Blue Cross and Blue Shield. IngenioRx, Inc. is an independent company providing pharmacy benefit management services and some utilization review services on behalf of Anthem Blue Cross and Blue Shield.

https://providers.anthem.com/oh

Anthem Blue Cross and Blue Shield Medicaid is the trade name of Community Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

OHBCBS-CD-015545-22 January 2023