Medicare Advantage Provider Orientation

Scott and White Health Plan

Scott&White
HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

Overview of Medicare Advantage

- SeniorCare Advantage is a Medicare Advantage product with multiple plan options
- All SeniorCare Advantage plan options include medical coverage (Medicare Parts A and B)
- Most SeniorCare Advantage plans also include Prescription Drug coverage (Medicare Part D)
- Covers all Original Medicare services, ***PLUS*** includes vision, hearing, and dental
- Follows the Centers for Medicare and Medicaid Services (CMS) guidelines
- Members may be responsible for copayments, deductibles, and coinsurance based on the plan that they select

Overview of Medicare Advantage (continued)

- Qualified Medicare Beneficiaries (QMBs)
  - QMBs are members that are eligible for both Medicare and Medicaid
  - Federal law prohibits Medicare Advantage providers from collecting Medicare Part A and Part B deductibles, coinsurance, or copayments from those enrolled in the QMB program, a dual eligible program which exempts individuals from Medicare cost-sharing liability
    - Balance billing prohibitions may likewise apply to other dual eligible beneficiaries in Medicare Advantage plans if the State Medicaid Program holds these individuals harmless for Part A and Part B cost-sharing
    - Balance billing prohibitions apply regardless of whether the State Medicaid Program is liable to pay the full Medicare cost-sharing amounts
    - Providers must accept the Medicare Advantage payment as payment in full or bill the State for applicable Medicare cost-sharing for enrollees that are eligible for both Medicare and Medicaid
    - This federal law applies to all Medicare Advantage providers and not just those that accept Medicaid
  - MA health providers may not refuse to serve enrollees because they receive assistance with Medicare cost-sharing from a State Medicaid program.
  - **References:** 42 CFR §422.504(g)(1)(iii); CMS Managed Care Manual, Chapter 4, Section 10.2.3 & 10.2.5

Overview of Medicare Advantage (continued)

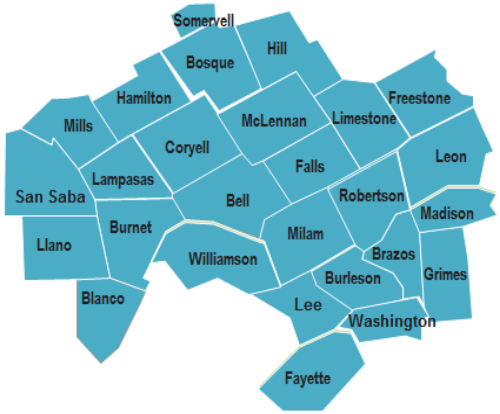
- No out-of-network benefits, except for urgent and emergent care for SeniorCare Advantage HMO
  - SeniorCare Advantage PPO includes out-of-network benefits with a separate cost sharing fee schedule
- SeniorCare Advantage HMO members must be referred to an ***in-network*** provider
- SeniorCare Advantage PPO members must be referred to an ***in-network*** provider to be eligible for in-network cost sharing
- Participating Provider Agreement language:
  - Except in Emergency Care situations, for fully-insured and Medicare replacement plans, a pre-condition to a health care service or product being a Covered Service may be that the service be provided by a Participating Provider, whether it be an individual or a facility. For such plans, absent an Emergency or approval of an ICSW Medical Director, Provider will make referrals and admit Covered Persons only to Participating Providers.
- Contracted providers are expected to coordinate care or work with SWHP/ICSW prior to referring a member to a non-contracted provider to ensure, to the extent possible, that members are receiving medically necessary services that are covered by their Medicare Advantage plan.

Medicare Advantage (MA) 2019

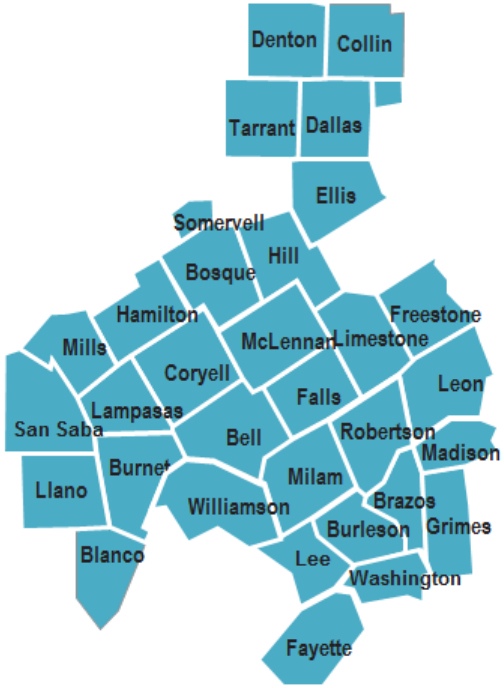
- Current MA Providers will be part of the 2 networks regardless if the provider is in Central Texas or North Texas.
  - SeniorCare Advantage HMO (Central Texas)
  - SeniorCare Advantage PPO (Central and North Texas)

- Detailed benefit information for each plan is located on our website http://medicare.swhp.org/en-us/.

SeniorCare Advantage HMO Service Area

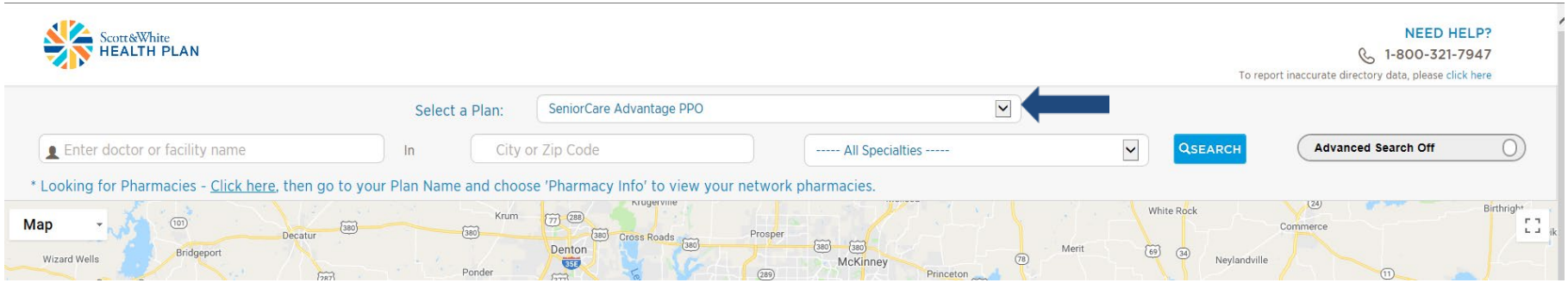


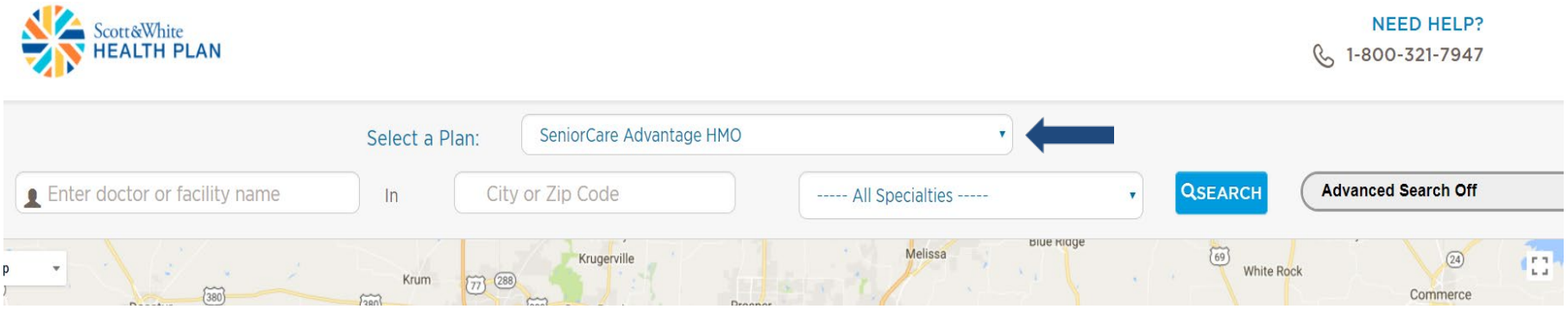
SeniorCare Advantage PPO Service Area



Find a Provider Search

Find a Provider Search: https://portal.swhp.org/#/search





Medicare Advantage Member ID Cards

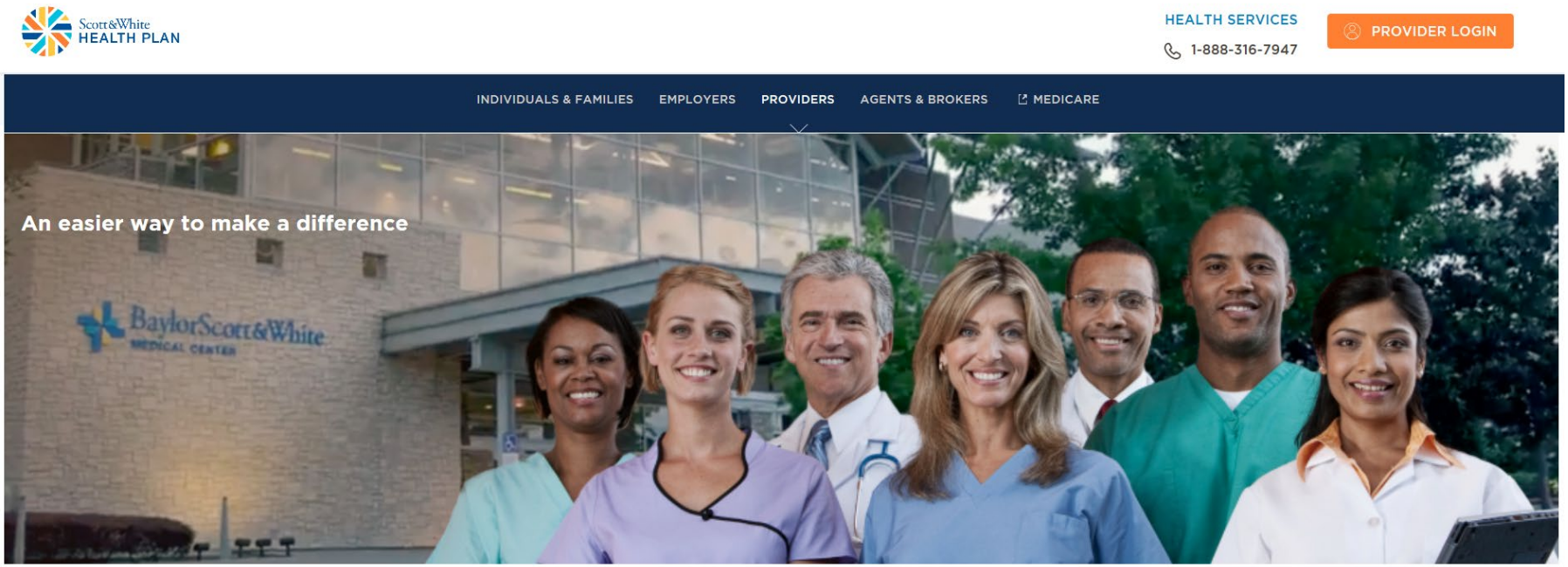
Scott and White Health Plan offers HMO and PPO Medicare Advantage plans. These plans provide all the benefits of Original Medicare but may include extra benefits such as vision, hearing, fitness, and dental, depending on the plan.

HMO

PPO

SWHP Website

Provider-Specific Information: http://swhp.org/en-us/prov



The SWHP website is a valuable resource for providers to obtain information on the following:

- Claims & Billing
- Prior Authorizations
- Provider Services
- Resources
- Forms & Guides
- Quality Improvement
- Policies
- Member Eligibility & Benefits

Provider Contracting & Services

- Join Our Network Form
  - *You must be enrolled in Medicare to participate in the Medicare Advantage network.*

    - http://swhp.org/en-us/prov/services/join
- Add Provider to Existing Contract Form

    - https://swhp.org/en-us/prov/add-a-provider-form
- Provider Change of Address

    - https://swhp.org/en-us/prov/provider-address-change-form
- Modify Existing Contract Form

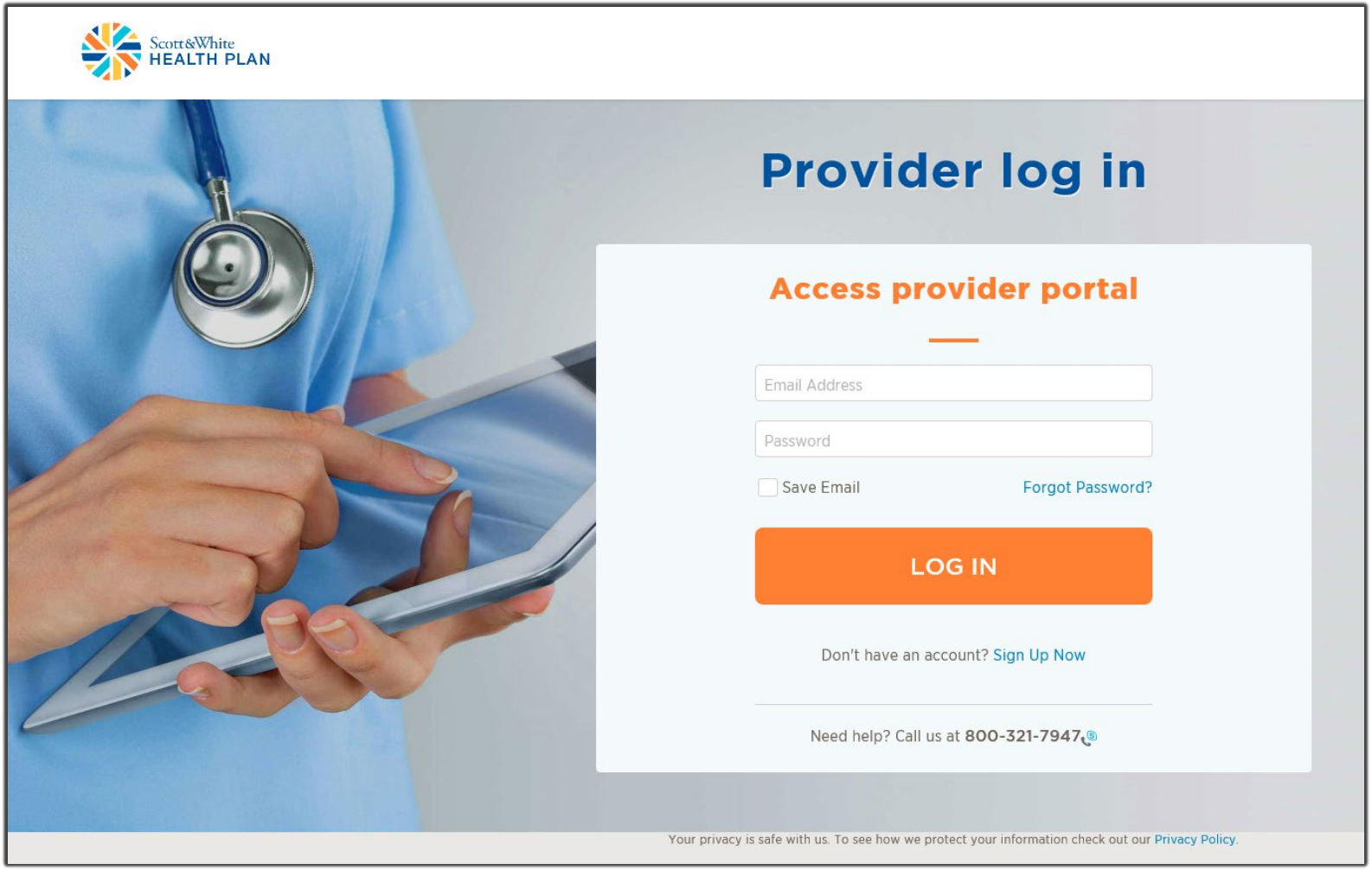
    - https://swhp.org/en-us/prov/modify-existing-contract
- Terminate Provider Contract Form

    - https://swhp.org/en-us/prov/terminate-provider-contract-form

SWHP Provider Portal

- Providers can access the SWHP Provider Portal at:
  - https://portal.swhp.org/#/login
- SWHP Provider Portal can be utilized for the following:
  - Check Member Eligibility & Benefits
  - Check Claims & Payment Status
  - Look up Codes to Determine Prior Authorization Requirements
  - View Explanation of Claim Denial Codes
  - Look-Up Reimbursement Rates by Code
  - Submit Case Management Referral Forms
  - Submit Prior Authorization Request Forms
  - Register as a Group Provider
  - Add Additional Provider to an Existing Registration (using individual NPI's)
  - Submit Redeterminations

SWHP Provider Portal



Claims & Billing

- Electronic Claims
  - SWHP *strongly* encourages providers to submit claims electronically
  - Accept direct Electronic Data Interchange (EDI) submissions or submissions through Availity Clearinghouse
  - Electronic claims can be submitted to Payer ID: 88030
  - Details at SWHP website: http://swhp.org/en-us/prov/claims/electronic

- Paper Claims
  - SWHP will accept paper claims that are properly filed on UB-04 or CMS 1500 Claims Forms
    - All claim forms must be typed; handwritten forms are *not* accepted
    - Faxed claim forms are *not* accepted
  - Paper claims can be mailed to:

    Scott & White Health Plan
    ATTN: Claims Department
    PO Box 21800
    Eagan, MN 55121-0800
  - Details at SWHP website: http://swhp.org/en-us/prov/claims/paper

Claims & Billing (continued)

- Claims Processing Times
  - SWHP follows the Texas Department of Insurance (TDI) regulation for the processing of claims
  - Electronic claims are processed within 30 days; paper claims within 45 days
  - SWHP encourages the billing of claims electronically for faster payment

- Rejected Claims
  - Electronic Claims
    - Providers should review the clearinghouse rejected claims report to determine why the claims were returned to them through their billing system
  - Paper Claims
    - Rejected paper claims are returned with a paper rejection letter
    - Providers are encouraged to work rejected claims timely and resubmit within the filing deadline: 365 days for Medicare

Redeterminations

- Definition:
  - The review of a previously adjudicated / processed claim at the requ*est of a provider to assess* if the original determination/decision was correct or should be reversed based on additional information not previously available during the original determination. More information available on the SWHP website at: http://swhp.org/en-us/prov/claims/resources/appeals
- Process:
  - Providers must submit the *Provider Claim Redetermination Request Form* located on the SWHP website http://swhp.org/en-us/prov/claims/resources/appeals.
  - Providers now have the option to submit the *Claim Redetermination Request Forms* electronically through the provider portal.
  - Providers or inquiring parties will have only one (1) opportunity to submit a redetermination request on a claim. Multiple requests submitted on a single claim will not be processed and will be returned as "previously reviewed".
  - Provider should attach any pertinent supporting documentation i.e. retro authorization, proof of timely filing, surgical notes, office visit notes, pathology reports, and/or medical records.
  - Requests for Redeterminations must be submitted within 90 days from the original determination date. (120 days for Medicare Advantage Claims; 1 year for Out-of-State Providers).

Appeals and Complaints

- Appeals
  - Definition: Provider, on behalf of the member, or Member requests reconsideration of an adverse determination related to a request for medical services such as a prior authorization request.

- Complaints
  - Definition: member or provider expression of any dissatisfaction.

- Process
  - Contact customer service to file an appeal or complaint with a Customer Service Advocacy agent. The agent will route the appeal or complaint to the appropriate area. *Process is the same for appeals and complaints. Customer service phone number (800)321-7947 or (254)298-3000.

Provider Payment Options

- SWHP offers the following payment options through Change Healthcare
  - **Virtual Credit Card (VCC)**
    - Providers can receive payment by processing it as a credit card; funds are immediately available; fees may be assessed
    - If payment is not accepted within 90 days, a paper check will be mailed
    - Provider will have to opt-out of this method if they choose to utilize another payment method
      - To opt-out of the VCC payment method, please contact Change Healthcare at 866-506-2830 – select option 1.
      - To select Automatic Clearinghouse (ACH) or Electronic Funds Transfer (EFT), visit www.changehealthcare.com\EFT
  - **Electronic Funds Transfer (EFT)**
    - Payments are sent directly to the provider's bank; typically received within 3-5 business days
  - **Paper Check**
    - A paper check is mailed to the provider's billing or claims payment address on file

Account Reconciliation (Retractions/Recoupments)

- SWHP is dedicated to identifying and resolving accounting issues in a timely manner
  - Proper documentation will result in error reduction, which will result in quicker payments
  - **Retractions/Recoupments:**
    - Retractions/recoupments are made for various reasons, including:
      - Duplicate payment on a procedure
      - Incorrect payment on a procedure
      - Payment to the wrong provider
    - To initiate a retraction, please complete a *Provider Appeal Request Form* located at: https://swhp.org/Portals/0/Files/Forms/Providers/Claims%20Forms/ProviderClaimAppealRequestForm_4.pdf

Account Reconciliation (Returned/Refund Checks)

- Returned Checks
  - If a SWHP check is returned for an adjustment, attach all documentation with an explanation for the returned payment
    - Be sure to include a copy of the Explanation of Payment (EOP), copies of prior payments, and any other documentation explaining the payment discrepancy

- Refund Checks
  - For all SWHP member claims, providers should send refund checks to the following address to reimburse money owed to SWHP:

Scott & White Health Plan
ATTN: Claims Adjustment Department
PO Box 840523
Dallas, TX 75284-0523

Quality Improvement (QI) Program

- Ensures SWHP is providing the highest quality of care that is easy to access and affordable to our members
- “Triple Aim” Goal: improving member’s affordability, quality, and experience of care
- Quality programs and improvement projects are designed to improve member outcomes through systematic ongoing measurement, care coordination, and continuous evaluation of results
- For more information on the QI Program, please visit the SWHP website at: http://swhp.org/en-us/prov/resources/provider-manual/quality-improvement

HEDIS

- Healthcare Effectiveness Data and Information Set (HEDIS)
  - HEDIS is a tool used by more than 90% of U.S. health plans to measure performance on important dimensions of care and service
  - Altogether, HEDIS consists of 95 measures across 7 domains of care
  - SWHP uses HEDIS to measure clinical quality performance and evaluate the following areas of care:
    - Preventive services
    - Treatment of acute illness
    - Management of chronic illnesses
  - For more information on HEDIS, please visit the SWHP website at: http://swhp.org/en-us/prov/resources/provider-manual/quality-improvement

Medicare Star Rating

- What is the Medicare Star Rating System?
  - CMS' rating system for evaluating the relative quality of Medicare plans
  - All plans are measured on a scale of 1 to 5 Stars, with 5 Stars representing the highest quality
  - CMS defines the Star Ratings as follows:
    - 5 Stars = Excellent performance
    - 4 Stars = Above average performance
    - 3 Stars = Average performance
    - 2 Stars = Below average performance
    - 1 Star = Poor performance

Medicare Star Rating (continued)

- Improved healthcare and quality for our members = Star Ratings
- Emphasis on preventive care and adherence will help to minimize acute care needs and decrease readmission rates
- What is the impact of higher Star Ratings?
  - Richer benefits to our members
  - Plans at 5 Stars can market and enroll members year-round
  - Improved financial returns
- How does a provider impact our Star Ratings?
  - Provider performance impacts nearly two-thirds of the Star measures and includes member surveys of provider performance
  - Following is a sample of some items for which CMS measures provider performance:
    - Appropriate medical care
    - Prescription drug management
    - Patient experience
    - Care coordination

Jimmo v. Sebelius Settlement Agreement

- On January 24, 2013, the U.S. District Court for the District of Vermont approved a settlement agreement in the case of *Jimmo v. Sebelius*. The settlement involves skilled care for skilled nursing facilities (SNFs), home health (HH), inpatient rehabilitation facility (IRF), and outpatient therapy (OPT) benefits.
- The settlement agreement is intended to clarify that when skilled nursing or skilled therapy services are required in order to provide care that is reasonable and necessary to prevent or slow further deterioration, coverage cannot be denied based on the absence of potential for improvement or restoration. Conversely, coverage in this context would not be available when the member's needs can be met safely and effectively through the use of nonskilled personnel.
- The *Jimmo v. Sebelius* settlement agreement does not change existing Medicare coverage requirements. It only serves to clarify that, in the context of maintenance services, coverage does not turn on the presence or absence of potential for improvement, but on the need for skilled care.
- For detailed information and frequently asked questions, please visit the Centers for Medicare & Medicaid Services (CMS) website at: https://www.cms.gov/Center/Special-Topic/Jimmo-Center.html

Health Services Division (HSD)

- HSD includes:
  - Medical Directors
  - Nurse Managers
  - Licensed Clinical Social Workers
  - Administrative Staff

- Functions handled by HSD include:
  - Intake
  - Utilization Management Review/Prior Authorizations*
  - Case Management/Complex Case Management
  - Disease Management

- Phone Number: (888)316-7947 or (254)298-3088

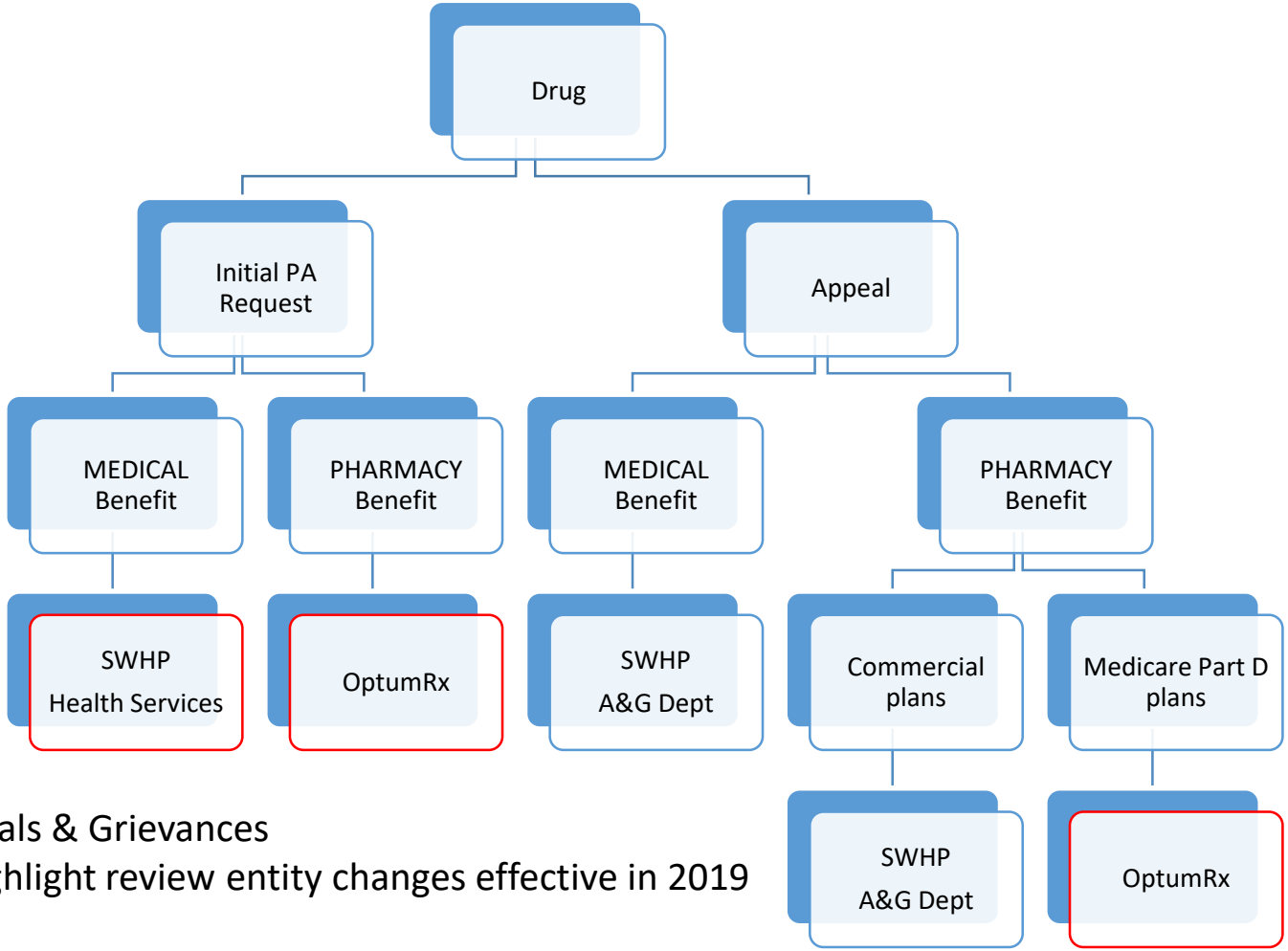
- Fax Number: (800)626-3042

* Prior Authorizations can now be requested through the provider portal.

Pharmacy Services

- OptumRx
  - Pharmacy network utilized by SWHP (*except for Medicaid*)
  - Processes pharmacy claims for SWHP (*except for Medicaid*)
- SWHP Prescription Drug Lists (Formularies)
  - Located on the SWHP website at: http://swhp.org/en-us/prov/resources/pharmacy-services/drug-list
- SWHP Medication Authorizations & Exceptions
  - Located on the SWHP website at: http://swhp.org/en-us/prov/auth-referral/medications
- Contact Information
  - Help Desk Phone Number: 1-844-230-9357

Drug PA & Appeal Requests – Review Entities



A&G – Appeals & Grievances

Red lines highlight review entity changes effective in 2019

Drug PA & Appeal Requests – Submission Details

Pharmacy Benefit Drug	Medical Benefit Drug (Drug to be billed on a medical claim – "buy and bill")
Initial / Renewal PA request	
ONLINE (OptumRx) **CoverMyMeds** http://go.covermymeds.com/OptumRx **SureScripts:** https://providerportal.surescripts.net/providerportal/ **PreCheck MyScript:** https://provider.linkhealth.com/#/	**ONLINE (SWHP)** https://portal.swhp.org/ProviderPortal/#/login/
FAX 800-527-0531 **(OptumRx)**	**FAX** 800-626-3042 **(SWHP)**
PHONE **Commercial plan:** 855-205-9182 **(OptumRx)** **Medicare Part D plan:** 844-230-9357 **(OptumRx)**	**PHONE** 1-800-321-7947 **(SWHP)**
MAIL OptumRx Attn: Prior Auth Exceptions P.O. Box 25183 Santa Ana, CA 92799	

Drug PA & Appeal Requests – Submission Details

Pharmacy Benefit Drug	Medical Benefit Drug (Drug to be billed on a medical claim – "buy and bill")
Appeals (Redeterminations)	
FAX **Commercial plan:** 254-298-3663 **(SWHP)** **Medicare Part D plan:** 877-239-4565 **(OptumRx)**	**FAX** 254-298-3663 **(SWHP)**
PHONE **Commercial plan:** 1-800-321-7947 **(SWHP)** **Medicare Part D plan:** 888-403-3398 **(OptumRx)***	**PHONE** 1-800-321-7947 **(SWHP)**
MAIL **Commercial plan:** SWHP c/o Appeals and Grievances 1206 West Campus Drive Temple, TX 76502 **Medicare Part D plan:** OptumRx Prior Authorization Department c/o Appeals Coordinator P.O. Box 25184 Santa Ana, CA 92799	**MAIL** SWHP c/o Appeals and Grievances 1206 West Campus Drive Temple, TX 76502

*Standard Medicare Part D redetermination (appeal) requests must be submitted in writing and cannot be initiated via phone. If you believe waiting 7 days for a standard Medicare Part D redetermination decision could seriously harm the member's life, health, or ability to regain maximum function, you can ask for an expedited decision; expedited Medicare Part D redetermination requests can be initiated via phone.

Fraud, Waste, and Abuse (FWA) Training

- CMS requires SWHP to ensure that our participating providers complete FWA training annually

- To address this CMS requirement, SWHP offers FWA training online at: https://swhp.org/en-us/prov/resources/fraud-waste-abuse-training

- Providers are also required to attest that they have completed the FWA training
  - Medicare FWA Training Attestation Form is located online at: https://legacy.swhp.org/providers/resources/fraud-waste-and-abuse-training-providers/fraud-waste-and-abuse-training

- SWHP understands that providers may have already completed FWA training for another Medicare plan or program
  - If that is the case, providers are asked to complete the Medicare FWA Training Attestation Form

Important Contact Information for SWHP

Provider Relations

Phone Number: (800)321-7947 ext. 203064 or (254)298-3064

Fax Number: (254)298-3044

Email Address: SWHPProviderRelationsDepartment@BSWHealth.org

Health Services Division

Phone Number: (888)316-7947 or (254)298-3088

Fax Number: (800)626-3042

SWHP Provider Portal:

https://portal.swhp.org/ProviderPortal/#/login

Provider IVR: (800)655-7947

Customer Service Department

Phone Number: (800)321-7947 or (254)298-3000

Part D Prior Authorizations / Appeals

- Coverage determinations: 844-230-9357
- Redeterminations: 888-403-3398