2017 Provider Workshop

Presented by Moda Health

Welcome

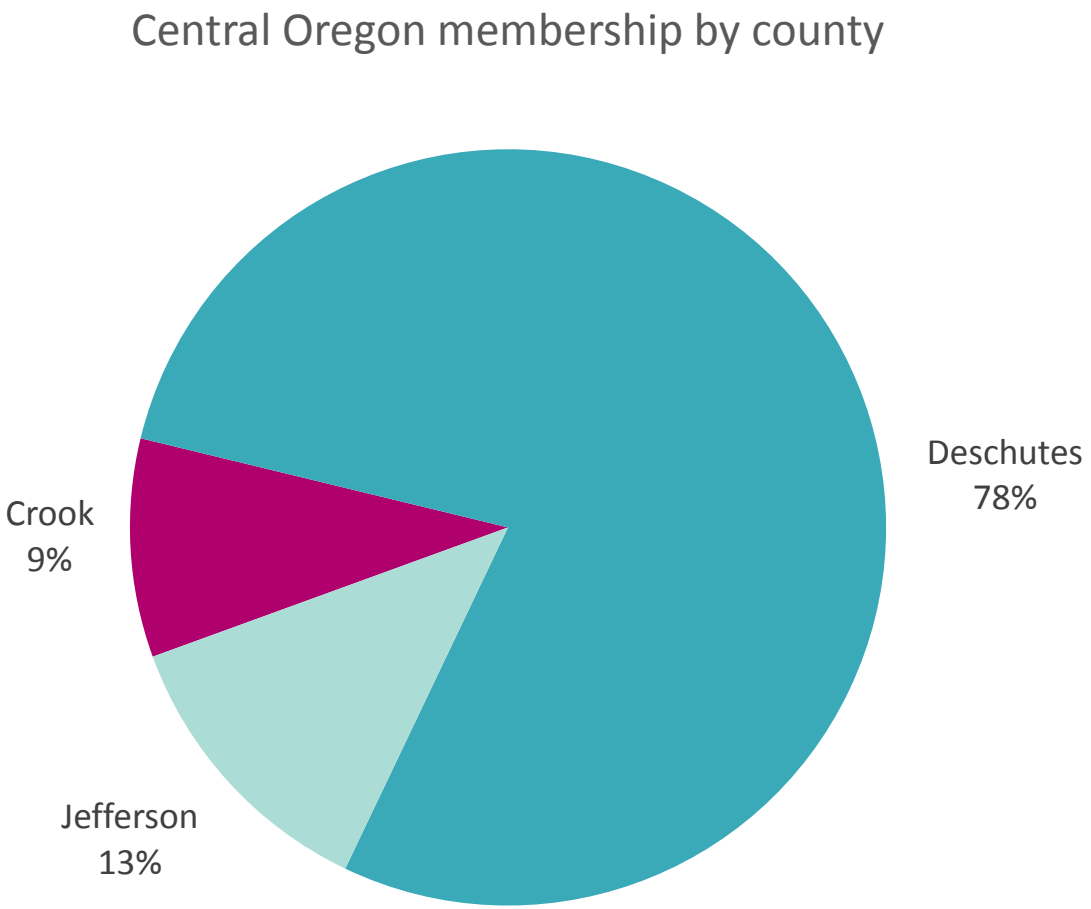
Agenda

- Organizational updates
- Commercial
  - 2018 Product updates
- Medicare
  - 2018 Product updates
  - EOC update/clarifications
- Medicaid

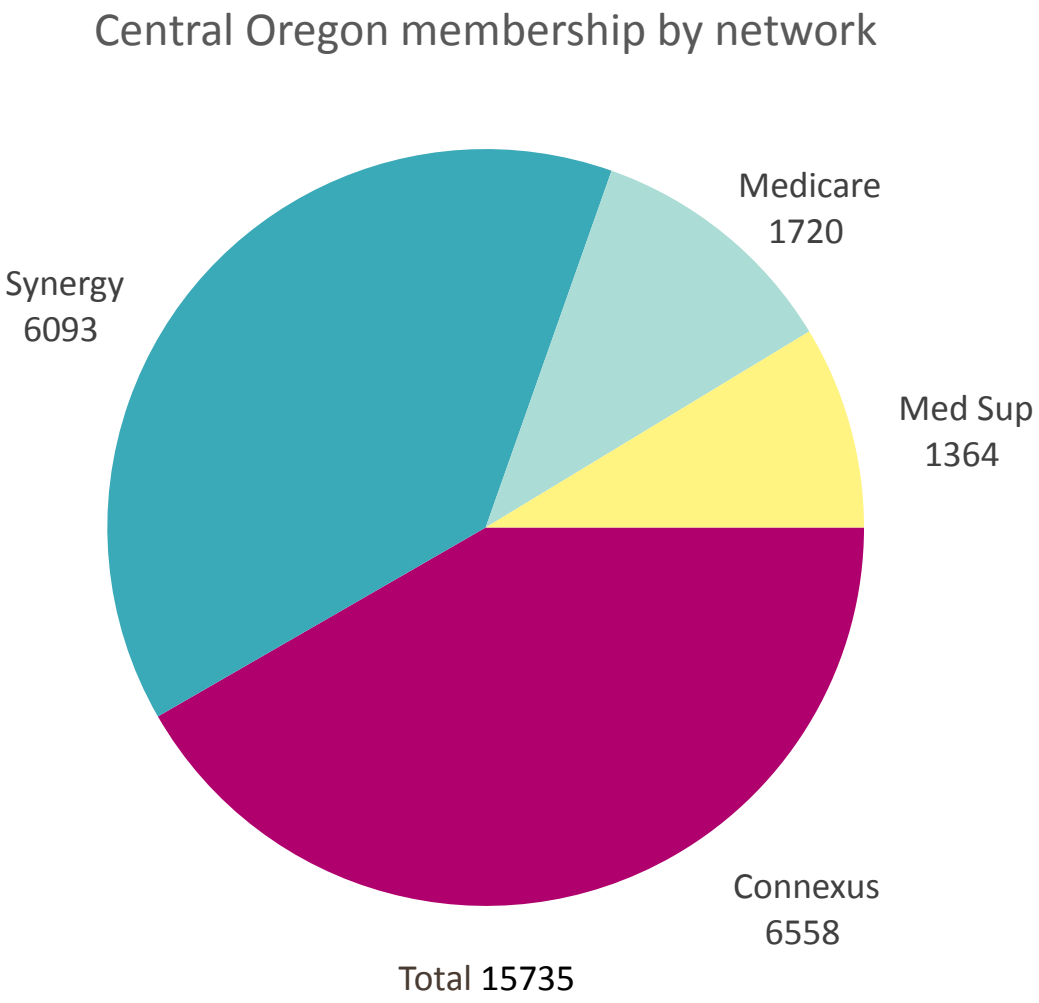
Organizational Updates

Membership

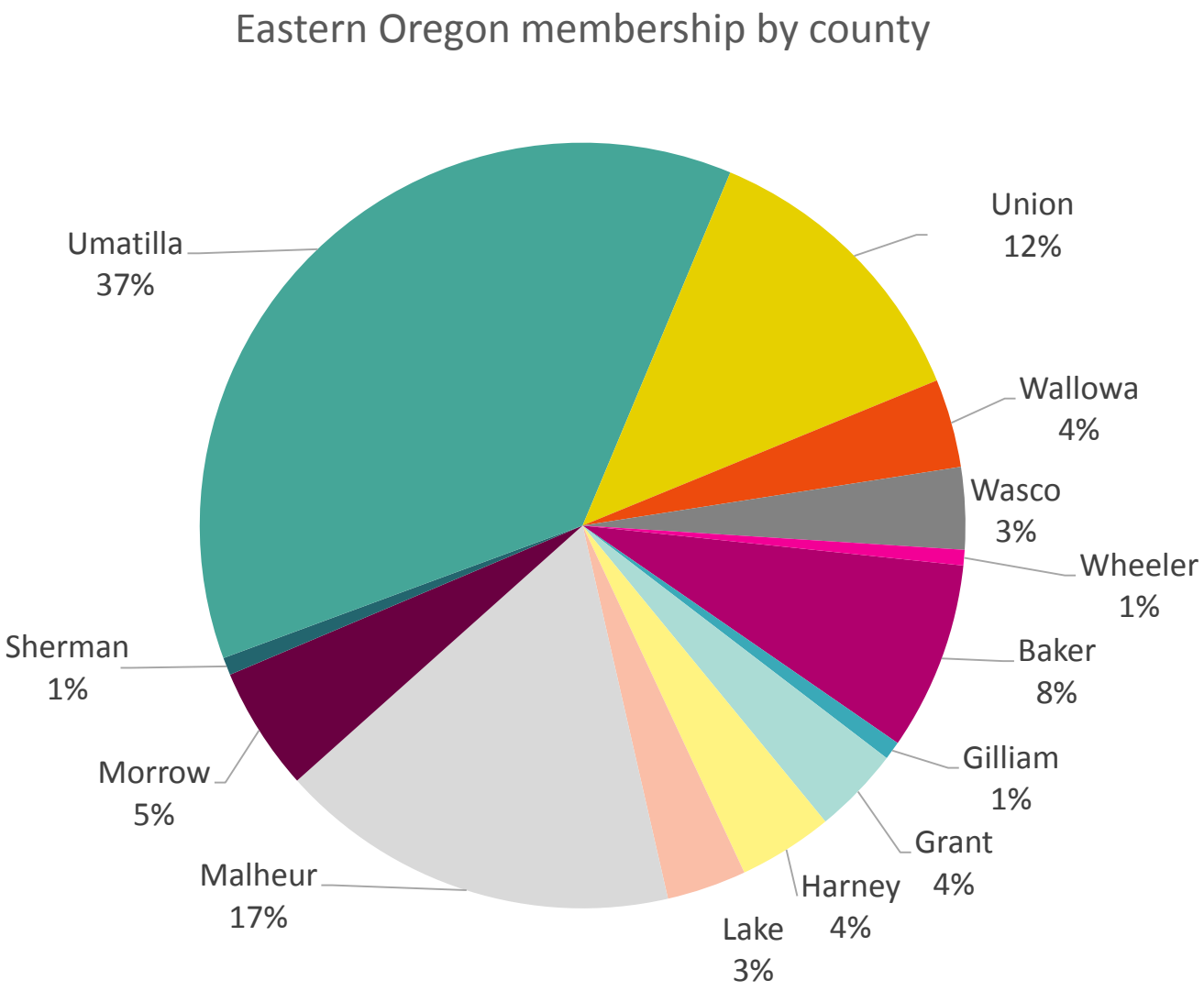
Central Oregon membership



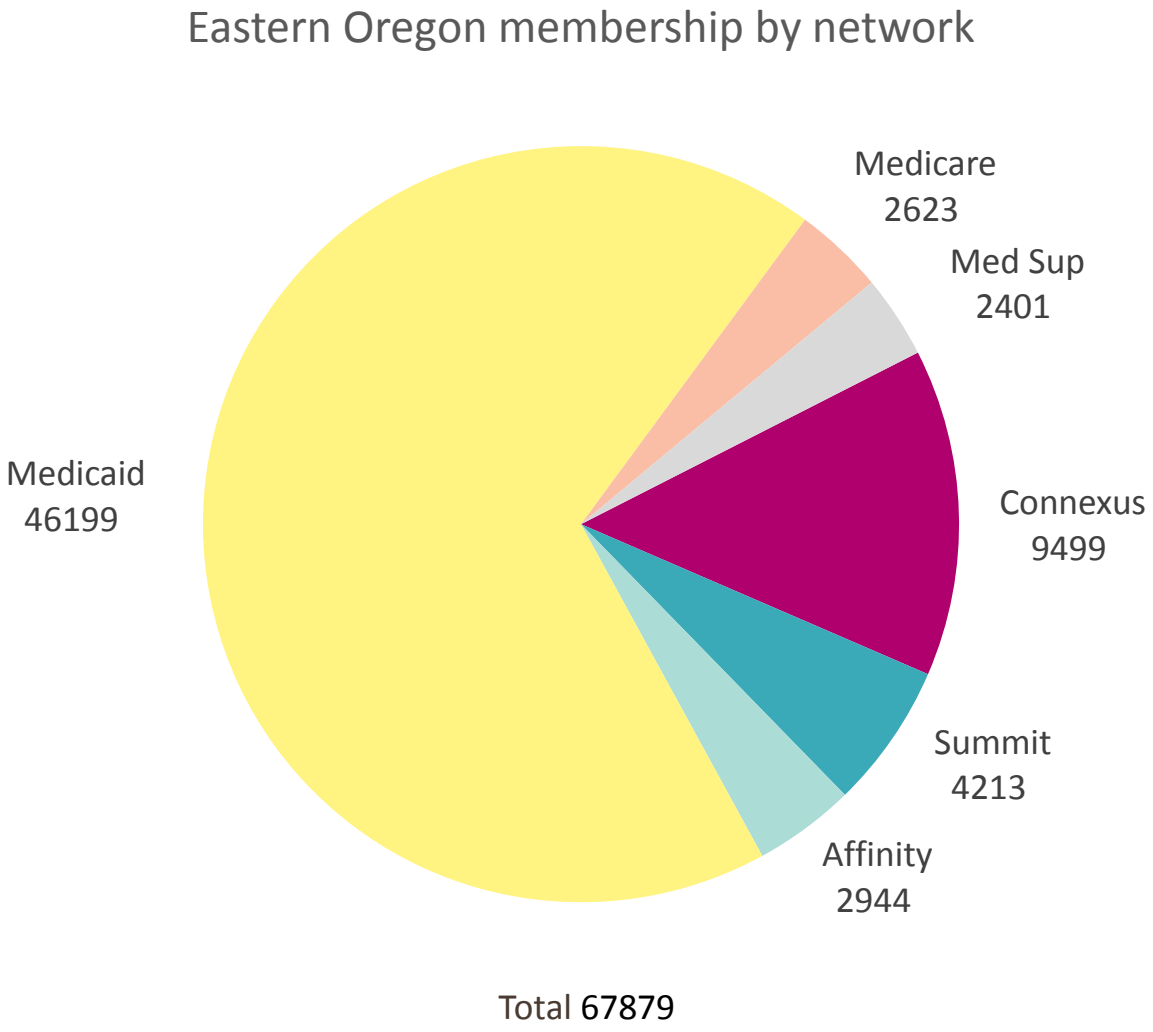
Central Oregon membership



Eastern Oregon membership

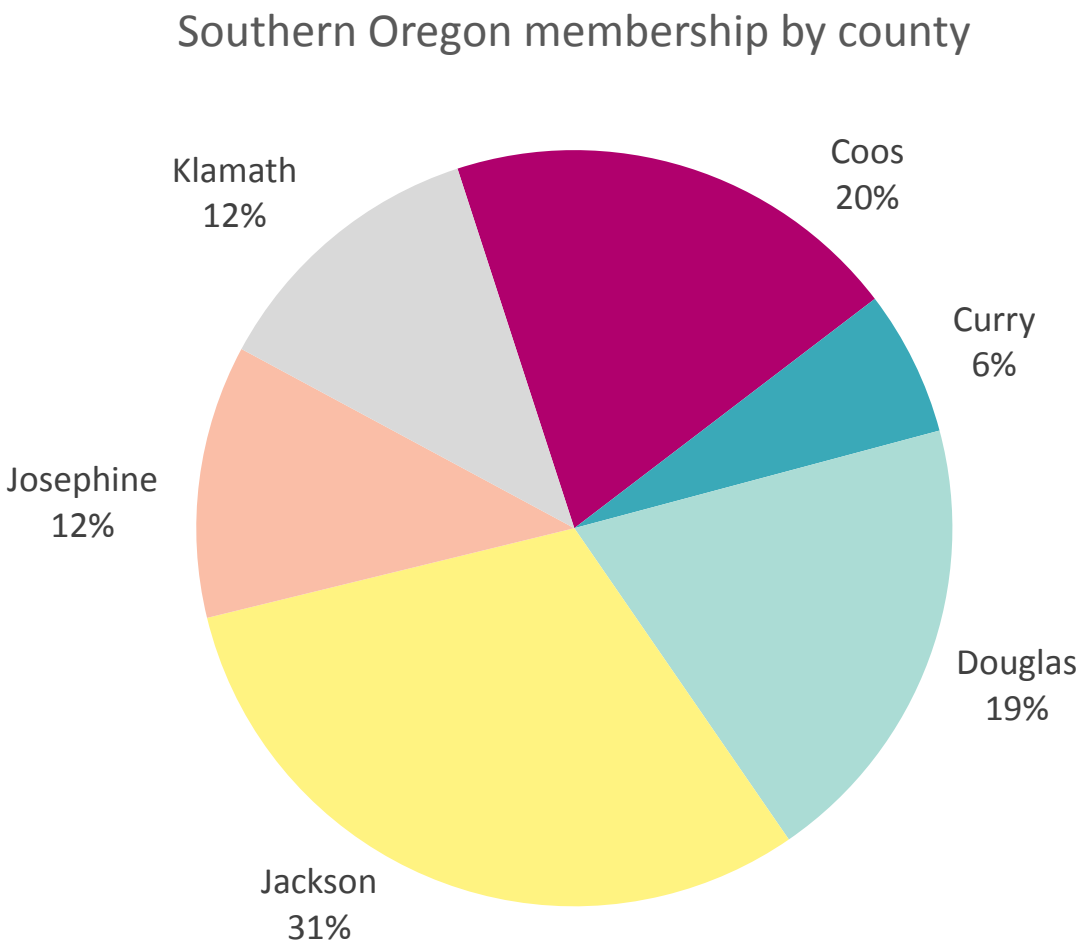


Eastern Oregon membership

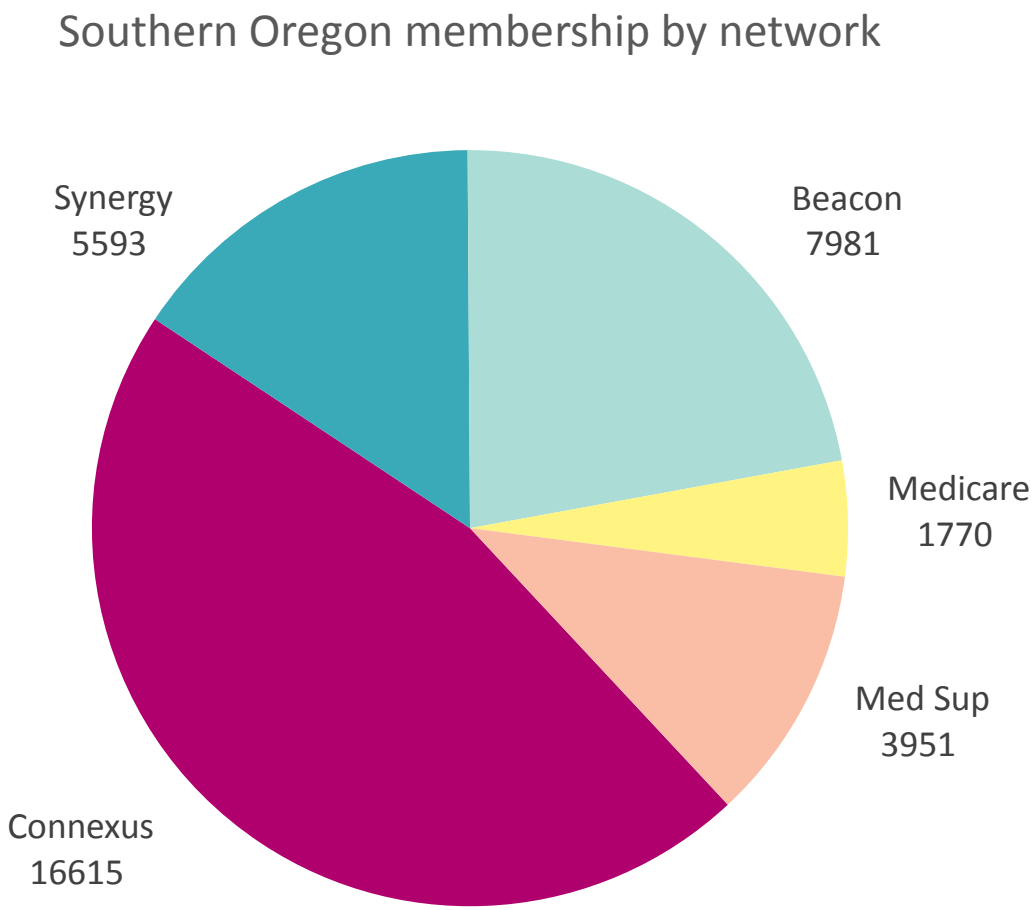


Total 67879

Southern Oregon membership

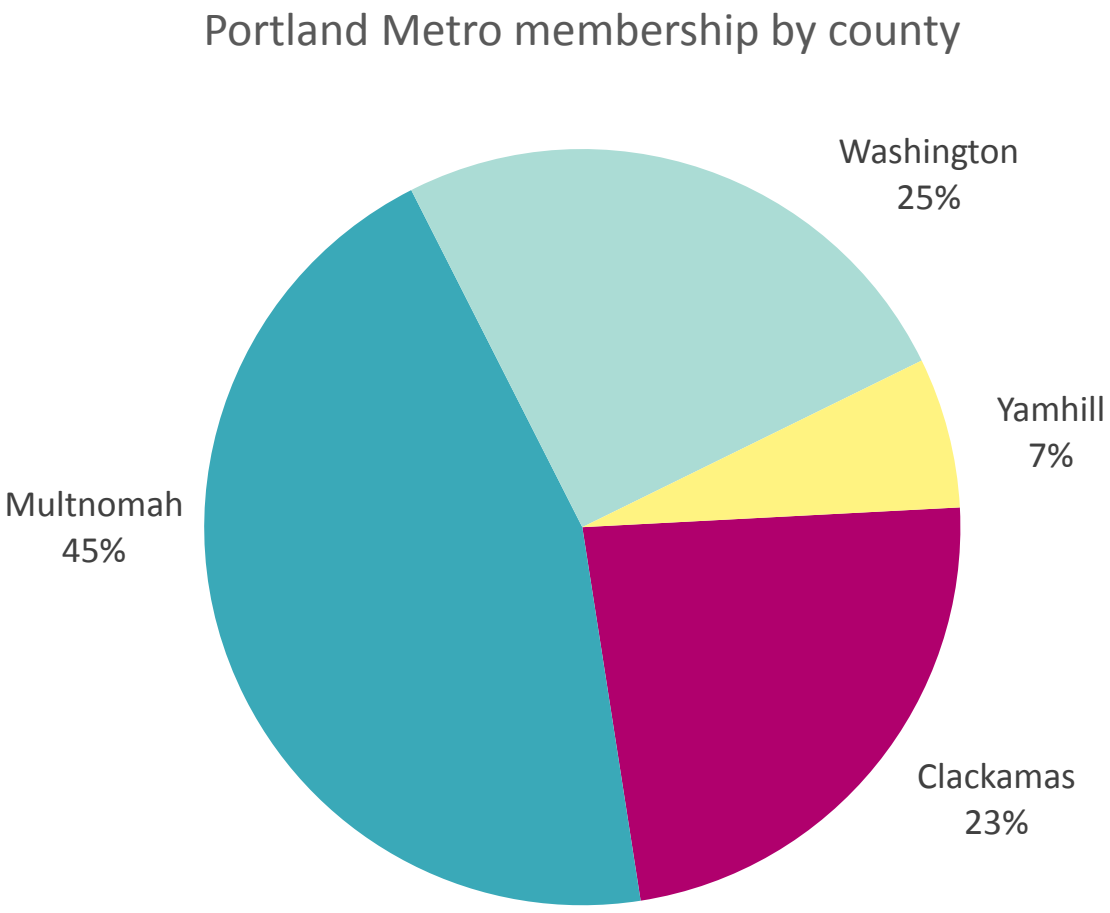


Southern Oregon membership

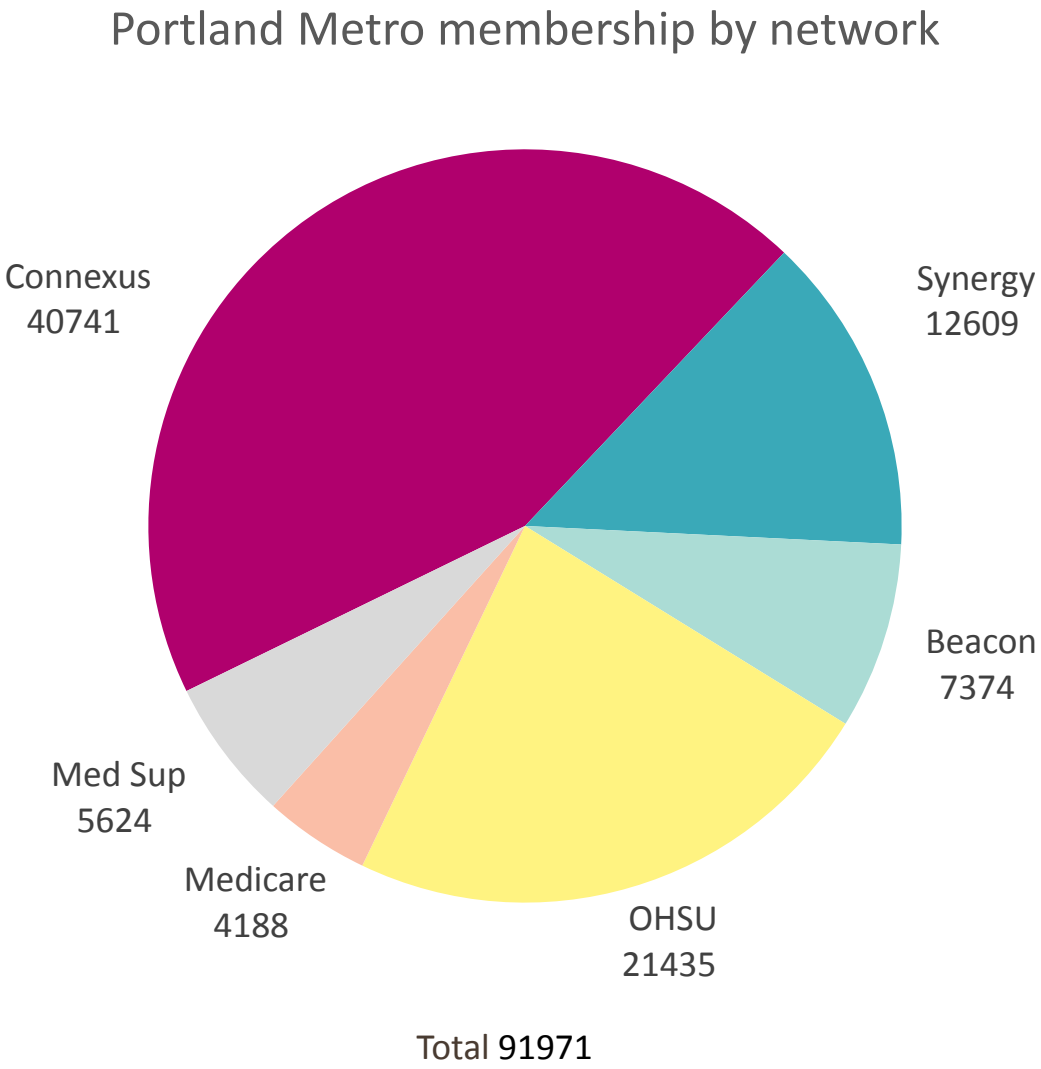


Total 35910

Portland Metro membership

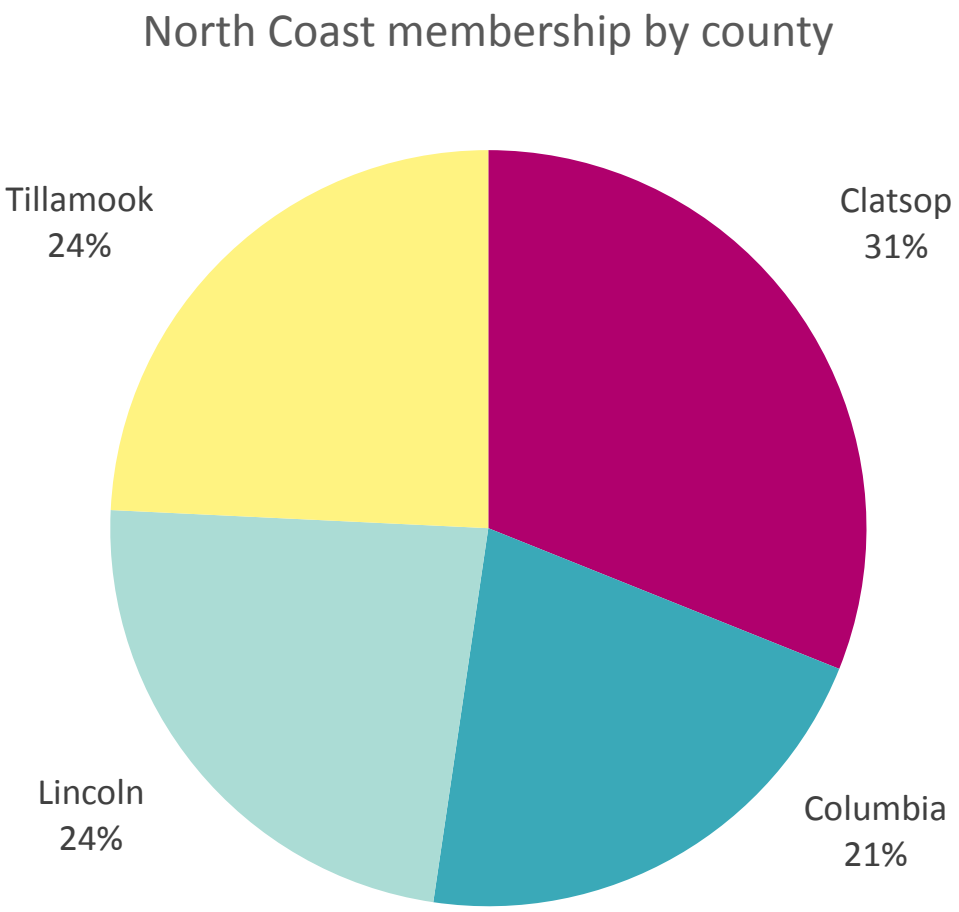


Portland Metro membership

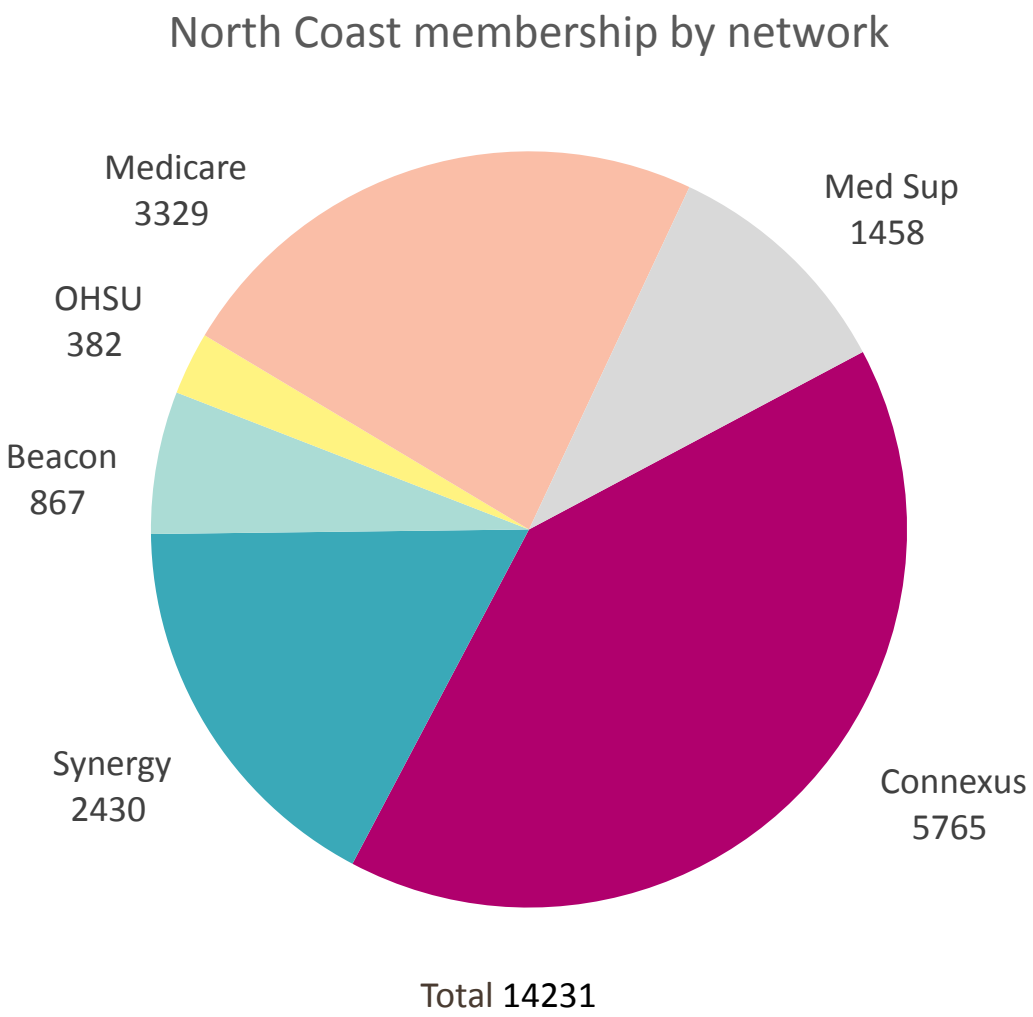


Total 91971

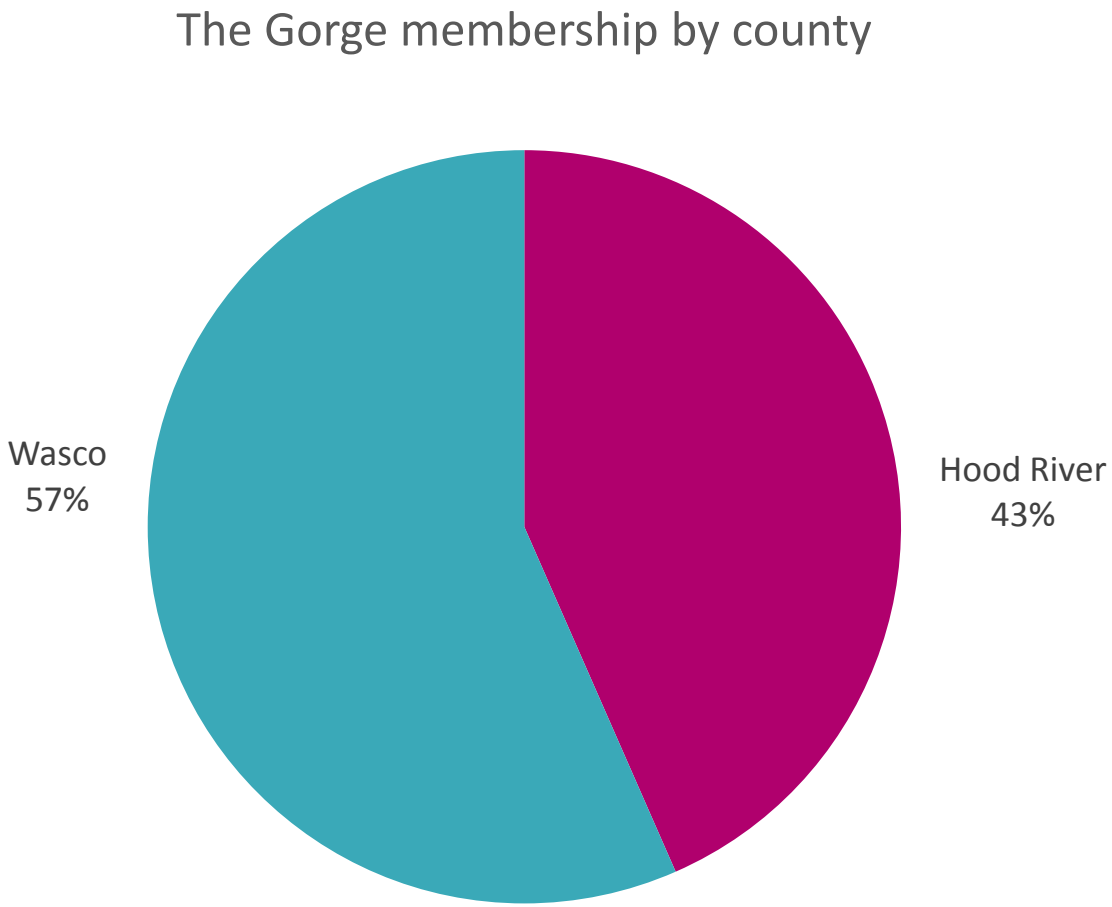
North Coast membership



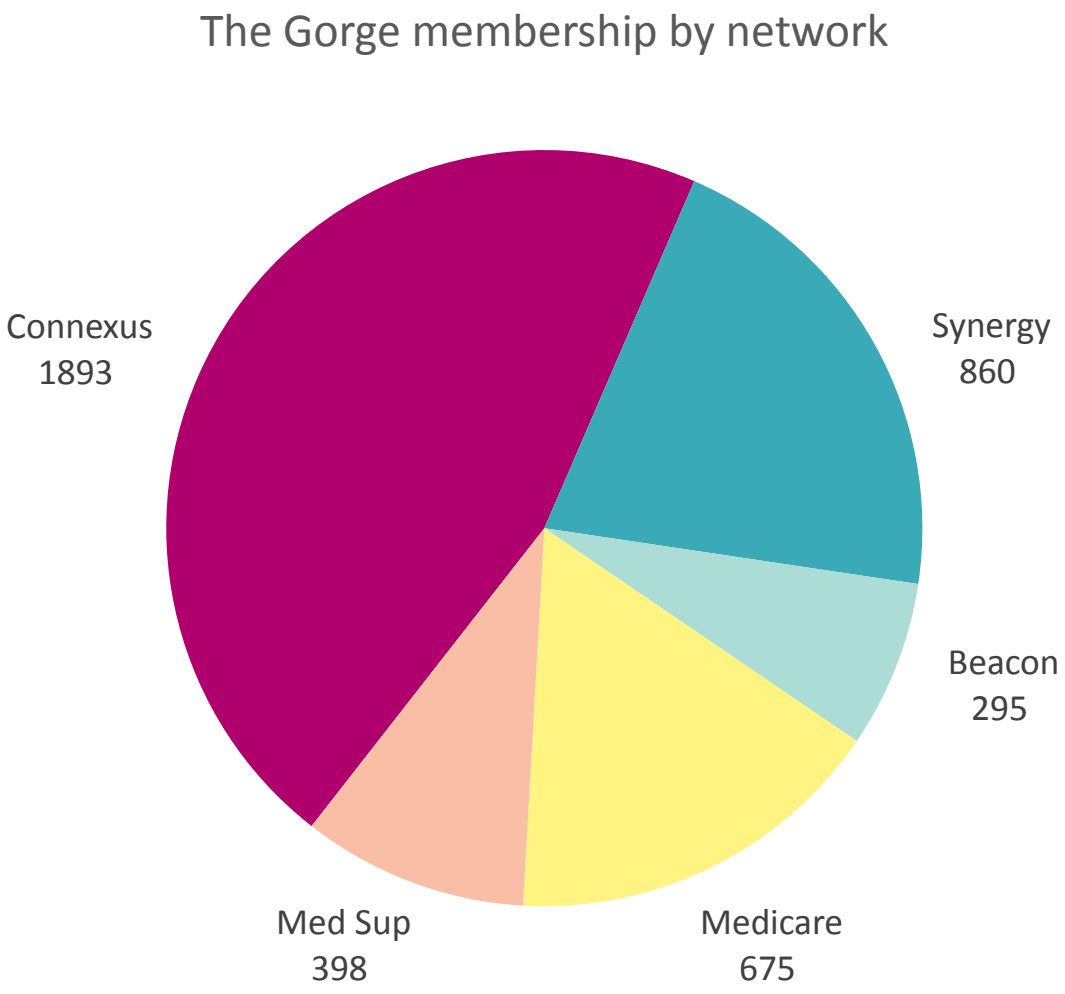
North Coast membership



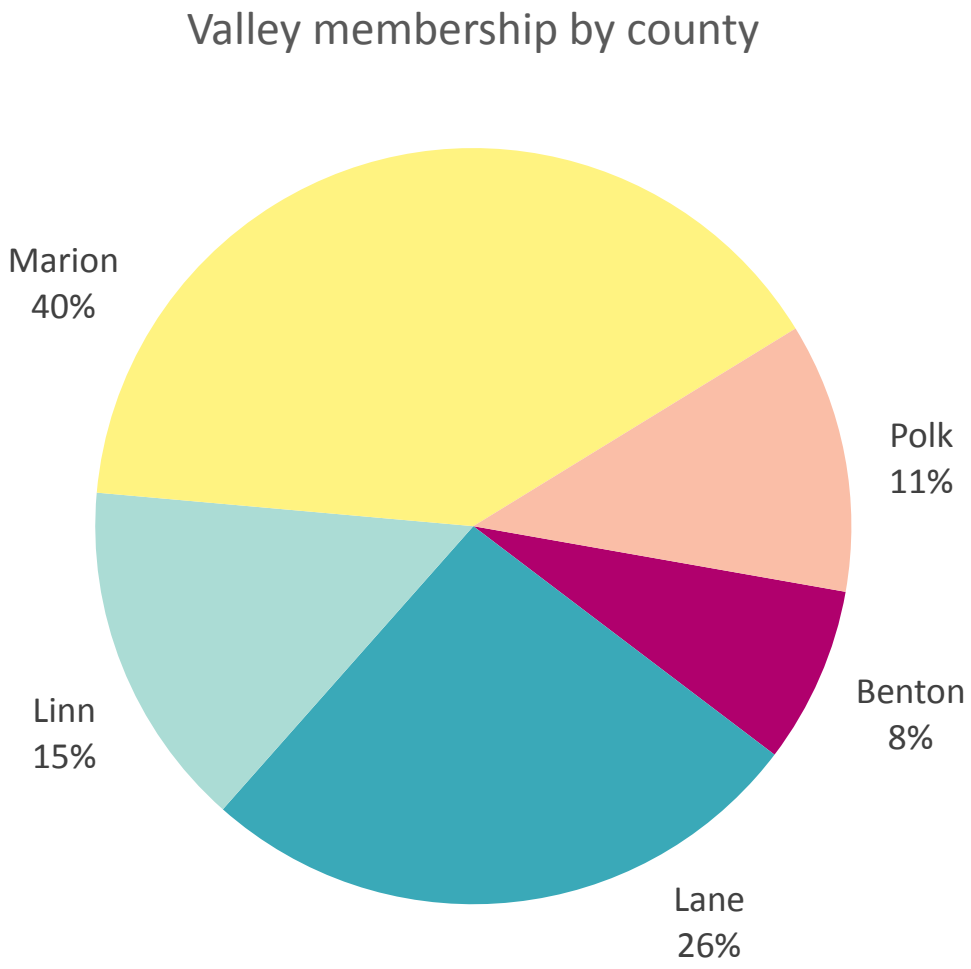
Gorge membership



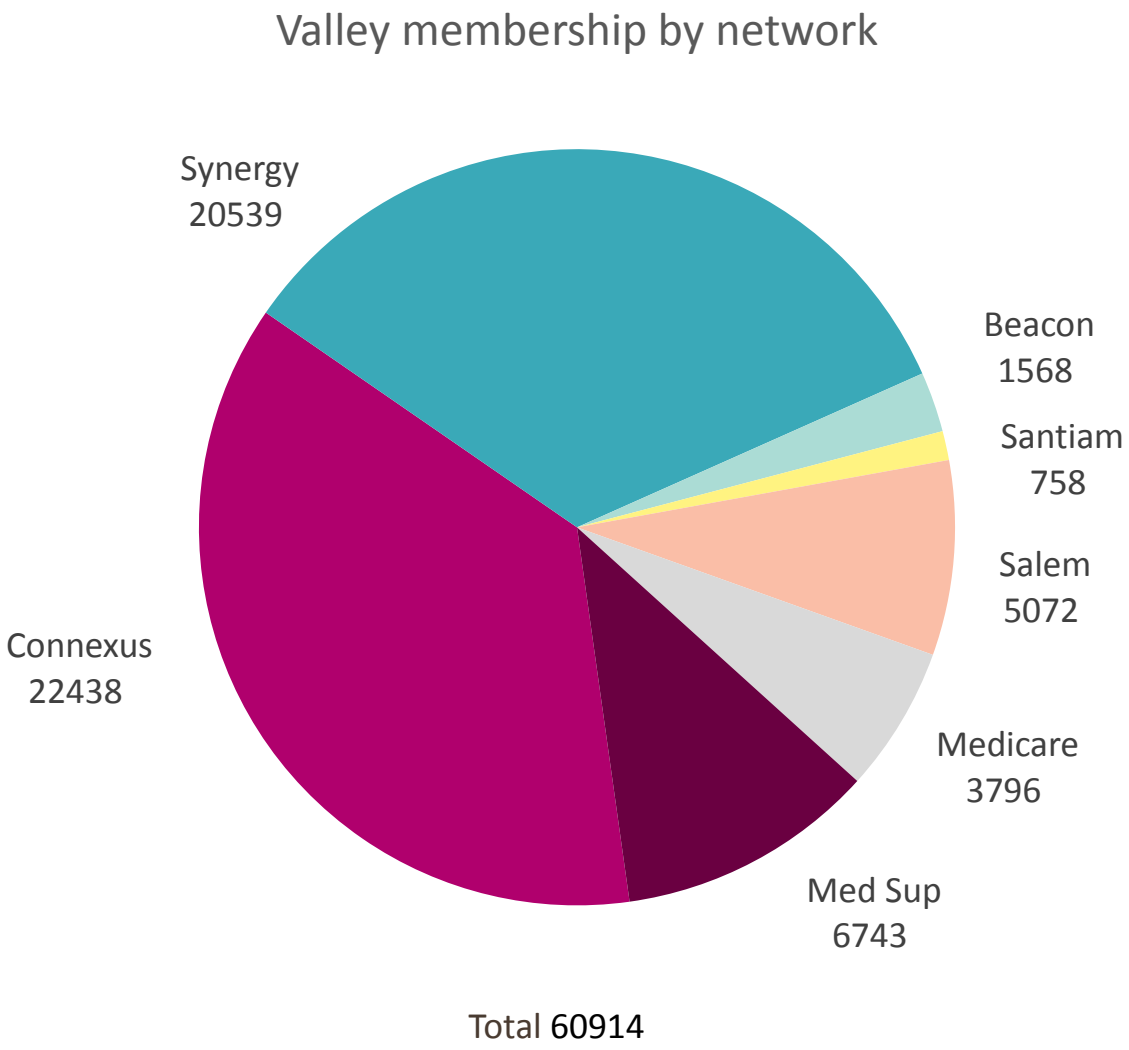
Gorge membership



Valley membership



Valley membership



Credentialing with Moda

Credentialing vs. Contracting

- **Credentialing** is the process of verifying a provider's credentials, including licensure, education and training. Credentialing approval allows the practitioner or organizational provider to be part of an in-network agreement.
- **Contracting** determines the reimbursement rate and in-network status for member plans. Separate lines of business are determined by the contracts negotiated.
- To be considered a Participating or In-Network provider, all providers must be both credentialed **AND** contracted.

Credentialing process

- As of Aug. 1, 2017, Moda is no longer using Medversant for credentialing.
- All non-delegated providers will need to submit initial and recredentialing applications and supporting documentation directly to Moda.
- Moda has received all applications submitted to Medversant prior to Aug. 1, 2017, and is processing these internally.

Oregon Common Credentialing Program

- SB 604 passed in 2013 to centralize credentialing information in Oregon.
- Businesses should benefit from the centralized process due to streamlined processes, decreased verifications and the ability to use a centralized system to manage credentialing information.
- Credentialing organizations will pay a one-time setup fee and annual subscription fees based on practitioner panel size as a proxy for system use.
- Providers will need to attest to their information every 120 days.

Oregon Common Credentialing Program

- Medversant was selected by the state to be Credentialing Verification Organization (CVO)
- Early adopters July 2018
- Mandated use late 2018
- Centralized provider directory
- Oregon Practitioner Credentialing Application (OPCA) to still be used
- FAQ: http://www.oregon.gov/oha/HPA/OHIT-OCCP/Pages/FAQs.aspx

Claims

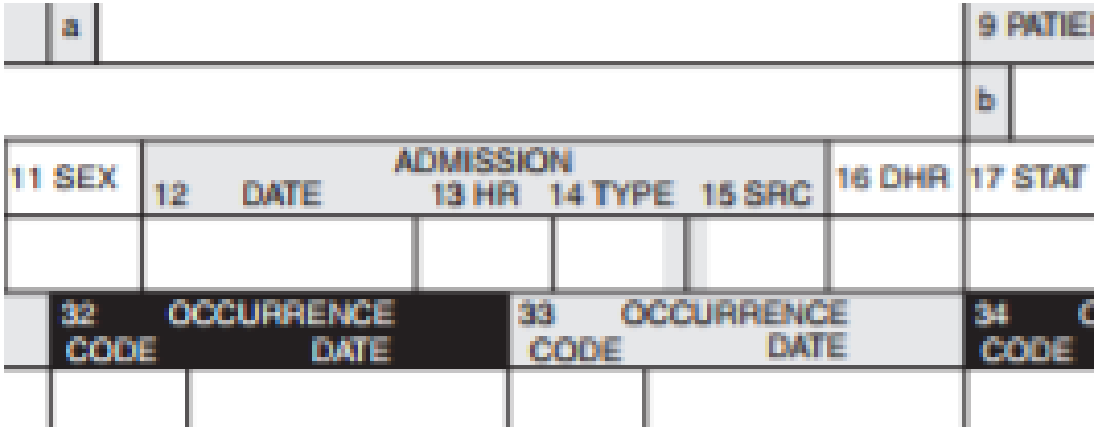
Billing reminders

Corrected claims

- HCFA-1500 (Professional)
  - Please indicate ‘CORRECTED CLAIM’ in Box 19 or near the top of the form.
  - Box 22 Resubmission Code is not programmed in our system to read as corrected claim.
- UB-04 (Facility)
  - Bill Type XX7 (in field 4) indicates a replacement of prior claim or corrected claim.

Facility claims

- Please make sure to complete Field 12 with Admission date and hour for Emergency Department claims
  - Reduces phone calls to verify multiple visits versus corrected claims



Modifiers 24 and 25

- Modifier 24 indicates that an unrelated E/M service was provided by the same physician during a postoperative period.
- Modifier 25 indicates a significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service.
  - Scenario: When a visit occurs on the same day as a surgery with no global days, but within the global period of another surgery AND the visit is unrelated to both surgeries, modifiers 24 and 25 are appropriate.

Modifier 50

- Modifier 50 is used to report bilateral procedures that are performed during the same operative session by the same physician in either separate operative areas (e.g. hands, feet, legs, arms, ears) or one (same) operative area (e.g. nose, eyes, breasts).
- When using modifier 50, the units should be reported as 1.

Modifiers 58, 78 and 79

- Modifier 58 is defined as a staged or related procedure or service by the same physician during the postoperative period.
- Modifier 78 is defined as an unplanned return to the operating/procedure room for a related procedure during a postoperative global period.
- Modifier 79 is defined as an unrelated procedure or service by the same physician during the postoperative period.
- These are considered valid for procedures with a Global Days indicator setting of 000, 010, 090 or ZZZ.

Modifiers 58, 78 and 79

- This is not valid for procedures with a Global Days indicator setting of XXX.
- These modifiers may not be appended to radiology codes, infusion administration codes, or other non-surgical codes. These also may not be used with E/M codes.
- When billing with these modifiers, please include medical records for the procedure with the Global Days indicator, as well as the current procedure.
- https://modahealth.com/pdfs/reimburse/RPM010.pdf

Disposable contact lens

- Disposable contact lenses should be billed with S0500, and units should reflect the number of lenses in the package.
  - For Commercial members only
- V2520 is only to be used for conventional contacts.
  - For Medicare members as CMS doesn’t recognize S codes

Global Maternity

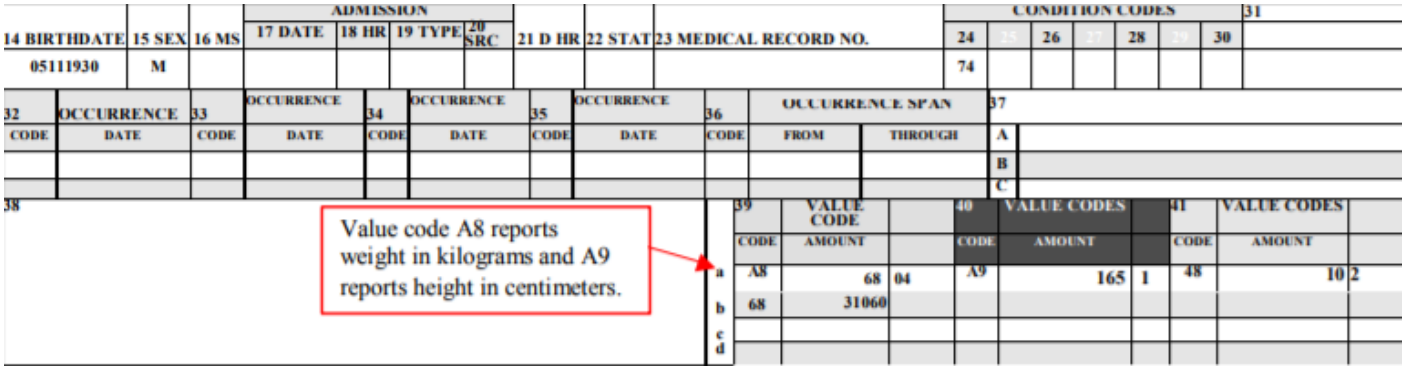
- Dates of service for the antepartum visits should be listed in the notes of a claim billed with global maternity codes
- Date of delivery should be noted as the date of service when billing global maternity codes
  - Claims billed with a date span will be returned for correction
- An itemized statement is required if member has less than six months consecutive coverage with Moda prior to the delivery date

Name matching

- Please make sure to bill with your legal business name.
- Only use your DBA if we have this listed in our system.
  - Only use nicknames or abbreviations if this is the DBA.
- Please use the member name as displayed on the member ID card or in the Electronic Benefit Tracker (EBT) on the claim forms.
  - Do not use a nickname.
  - Watch for hyphenations or spaces.

Kidney dialysis

- Dialysis facilities need to report value code A8 (patient weight in kilograms) and A9 (patient height in centimeters).
- Weight of the patient should be measured after the last dialysis session of the month.
- Height of the patient should be measured during the last dialysis session of the month. This is required no less frequently than once per year, but must be reported on every claim. The height is as the patient presents.



Kidney dialysis

The following factors are applicable to the base rate for adult patients after 1/1/2011:

- Onset of dialysis
- Patient co-morbidities
- Low-volume ESRD facility

Kidney dialysis

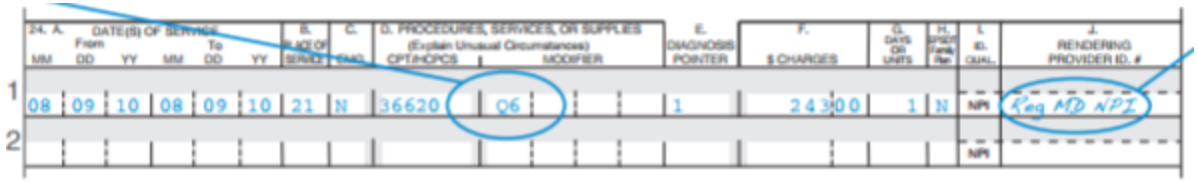
- Why is this needed?
  - The ESRD Pricer makes adjustments to the facility specific base rate to determine the final composite payment rate.

The following factors are used to adjust and make calculations to the final payment rate:

- Provider Type
- Drug add-on
- Budget Neutrality Factor
- Patient Age
- Patient Height
- Patient Weight
- Patient BSA (body surface area)
- Patient BMI
- BSA factor
- BMI factor
- Condition Code 73 (if applicable)
- Condition Code 74 (if applicable)

Locum Tenens

- Locum Tenens is defined by CMS as a substitute physician that takes over the professional practice when the regular physician is absent (for reasons such as illness, vacation, pregnancy, etc).
- Claims must contain the NPI of the regular physician in box 24J.
- Claims must contain modifier Q6 after the procedure code in box 24D.



Healthcare Services

Healthcare Services

- Healthcare Services utilize clinical decision support tools that include current knowledge and practices in clinical management and case management, and incorporate evidence-based guidelines and processes.
- MagellanRx and eviCore are two of the vendors that we partner with for utilization management.
- Health coaching and case management is provided to targeted member populations.

Prior Authorizations - eviCore

- eviCore
  - Advanced Imaging and musculoskeletal utilization management
  - Services that require Prior Authorization through eviCore are listed on our website www.modahealth.com/medical/utilizationmanagement.shtml
  - Does not apply to all members
  - Check Benefit Tracker to verify if member's plan utilizes eviCore

Authorizations:
- Phone: 503-243-4496
- Toll Free: 1-800-258-2037
- Fax: 503-243-5105

Plan has eviCore for all services (Advanced Imaging, Cardiology, Ultrasounds, Spine/Joint, Pain Management, PT/OT/SPT, Chiropractic and Acupuncture).

Evicore - Authorizations
- **Phone Number: (844) 303-8451**
- **Website: www.evicore.com**

Prior Authorizations – eviCore

How long is an eviCore authorization period?

- Advanced Imaging – 90 days
- Musculoskeletal Therapies – 60 days (previously 30)
- Musculoskeletal Spine and Joint programs – 45 days

eviCore extensions?

- Pain Management, Spine and Joint Surgery — No
- MSK Therapies — Yes (date extensions only)
- Radiology and Cardiology — No
- Ultrasound — Yes

Prior Authorizations – eviCore

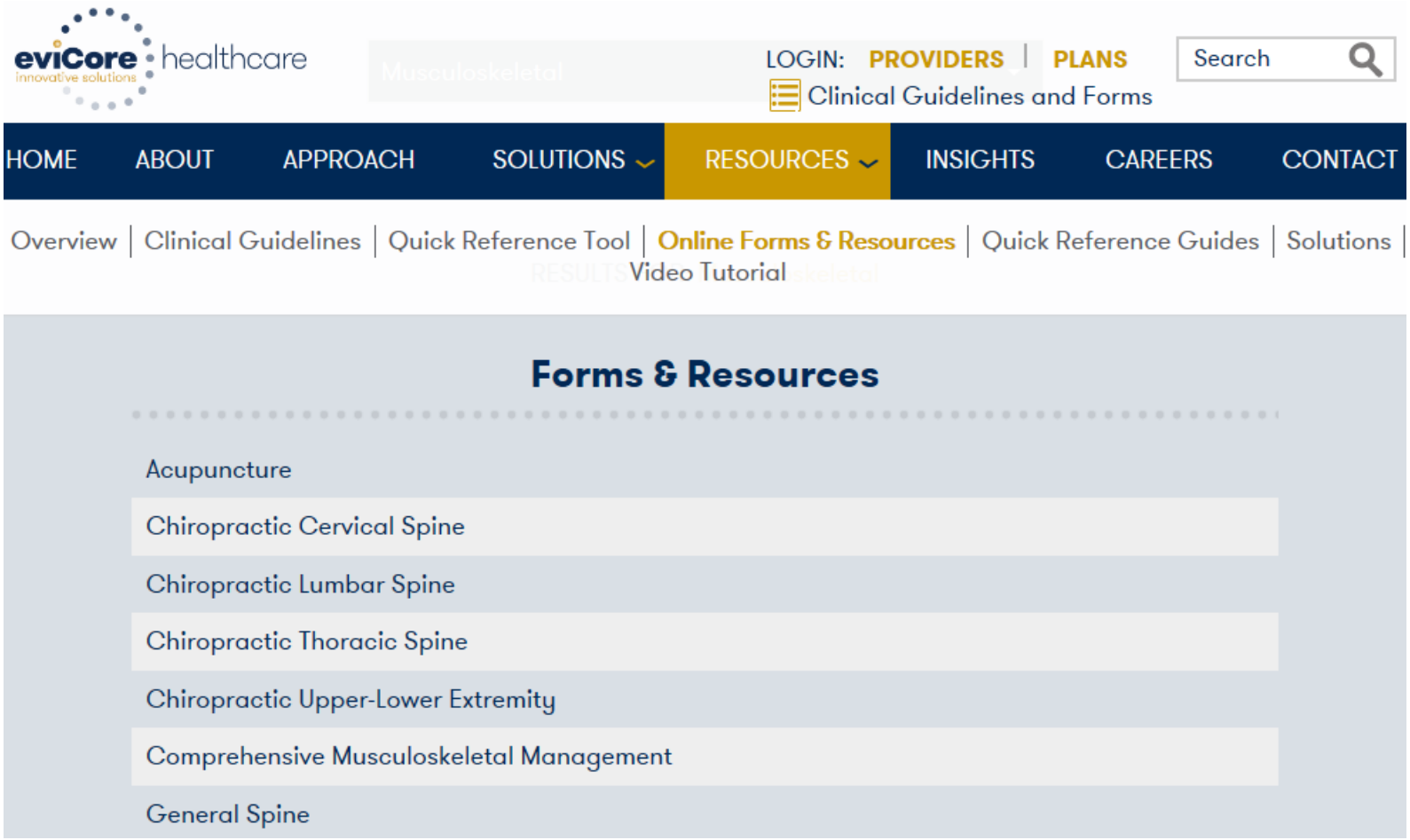
- eviCore Urgent Requests
  - Must be requested by phone **ONLY** — 844-303-8451
  - Must meet NCQA medically urgent criteria
  - Processed within 24-48 hours after all required information received
  - Medical Necessity review not required for inpatient observation and Emergency Department studies

Prior Authorizations – eviCore

Initial request denial

- Reconsideration review
  Additional clinical information available
- Peer-to-Peer discussion
  Scheduled with an eviCore Medical Director (now online)
- Member appeal
  Appeals process outlined in member handbook

eviCore online forms and resources



eviCore online forms and resources

Table of Contents

eviCore online forms and resources

1. Date of - Onset: Evaluation: Current findings:

2. What is the primary area(s) of complaint?

Head or Cervical Spine (M54.2) ☐ Right Arm (M79.601) ☐ Right leg (M79.604) ☐ Left leg (M79.605) ☐

Lower back/Lumbar spine (M54.5) ☐ Left Arm (M79.602) ☐ Upper back/Thoracic Spine (M54.6) ☐

Other:

3. Check any of the following which apply:

Member not treated in last 60 days ☐

Member requires treatment for a new condition ☐

Additional care for same condition treated in the last 60 days ☐

If member requires treatment for a new condition, answer questions 4-6:

4. What was the previous condition treated?

Head or cervical spine ☐ Upper extremities ☐ Upper back or thoracic spine ☐

Lower back/lumbar spine ☐ Other:

eviCore escalations

- Please provide:
  - Member ID Number
  - Member Name
  - Date and Time of call to eviCore
  - CPT requested
  - Diagnosis requested
  - Please describe the reason for escalation
  - Who should eviCore or EOCCO contact with a response?
  - Contact Phone number
- Securely email this information to clientservices@evicore.com and CC your Provider Relations Rep.

Prior Authorizations

- Prior Authorization/Always not covered lists
  - Located on our website: www.modahealth.com/medical/referrals/
  - Lists of CPT codes requiring Prior Authorization for both commercial and Medicare for 2017
  - List of CPT codes that are never covered by Moda
  - New Prior authorization forms for commercial. Medicare and EOCCO also available on Website
  - New for 2017 — No retro authorizations

Prior Authorizations

- Genetic Testing
  - Pre-test genetic counseling must be provided by a qualified and appropriately trained practitioner.
  - Information Submitted with the Prior Authorization Request:
    1. Provider chart notes
    2. Family history
    3. Documentation of pre-test genetic counseling
  - You can find the genetic testing Medical Necessity Criteria here: www.modahealth.com/pdfs/med_criteria/GeneticTesting.pdf

Healthcare Services

Magellan

- Six new medications added to the PA list effective July 1, 2017

Effective July 1, 2017	
Procedure code	**Brand name**
J3490	Spinraza
J9999	Bavencio
J3590	Ocrevus
J9999	Infinzi
J3490	Radicava
J3590	Renflexis

Site of Care

- Effective 10/1/2017, Magellan Rx has expanded to include a Site of Care program that directs members to the most cost-effective, yet clinically appropriate, location to receive their infusion(s) of select specialty medications.
- Through the current prior authorization program, infusion requests for a hospital outpatient setting will be redirected to a preferred site of service:
  - Preferred home infusion provider or
  - Professional office setting

Site of Care

- This applies to all fully insured Commercial members and all EOCCO members who begin using these medications on or after 10/1.
  - The Site of Care program does not apply to ASO groups.
- Coram is the preferred home infusion provider.
- OHSU prescribers may refer patients to OHSU Home Infusion Services.
- www.modahealth.com/medical/siteofcare.shtml

3-D mammography medical criteria

- OEBB/PEBB
  - Coverage effective April 1, 2017
- Oregon and Alaska fully insured and ASO groups
  - Coverage effective Jan. 1, 2018
- Medicare, currently covered
- Medicaid, currently not covered
  - Health Evidence Review Commission is actively reviewing

2018 ICD-10 updates

- ICD-10-CM updates effective 10/1/2017 include 363 new codes, 142 deleted codes and more than 250 revised codes
- ICD-10-PCS updates effective 10/1/2017 include 3,562 new codes, 1,821 revised codes and 646 deleted codes

Provider experience enhancements

Provider experience research

- In February of 2017, Moda Health's provider relations, analytics and marketing teams met with several provider groups to gain insight into how office staff works with Moda digitally, addressing Member Eligibility tools (Benefit Tracker), Synergy/Summit Provider Risk Share Reports, and Modahealth.com.
- The purpose of this research is to better understand what elements of a provider portal are most important to a practice for ensuring process efficiencies when serving Moda members.

Provider experience enhancements

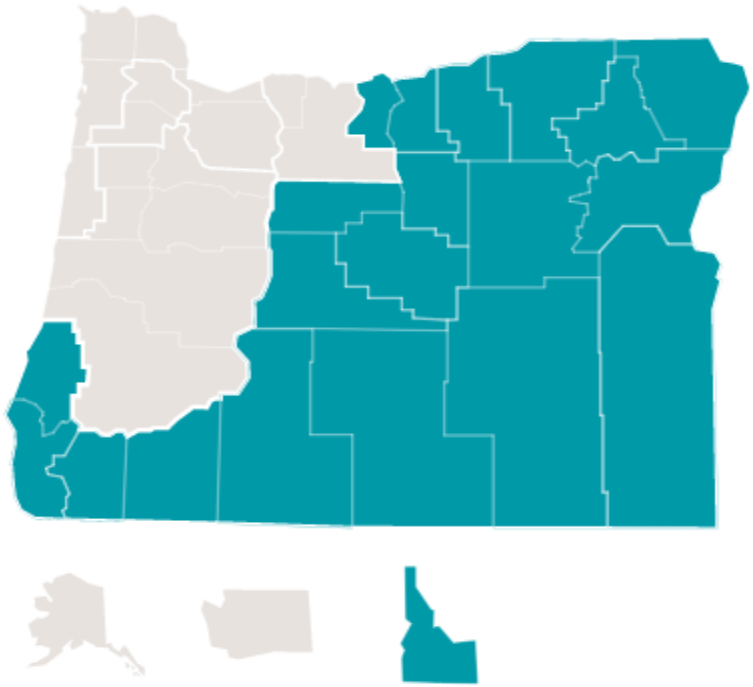
- Find Care
- Benefit Tracker refresh
  - Rebranded with Moda
  - Limited changes to functionality
  - Ability to submit referral for commercial HMO groups
  - Similar to redesign of Find Care that was completed in July 2017
- Provider resources
- www.modahealth.com/medical

Website updates

Find your rep

Just click on your service area to find your Moda Health representative and contact information.

Select your area on the map below



Sara Snider
sara.snider@modahealth.com
Serving Baker, Coos, Crook, Curry, Deschutes, Gilliam, Grant, Harney, Jackson, Jefferson, Josephine, Klamath, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, and Wheeler Counties and ID

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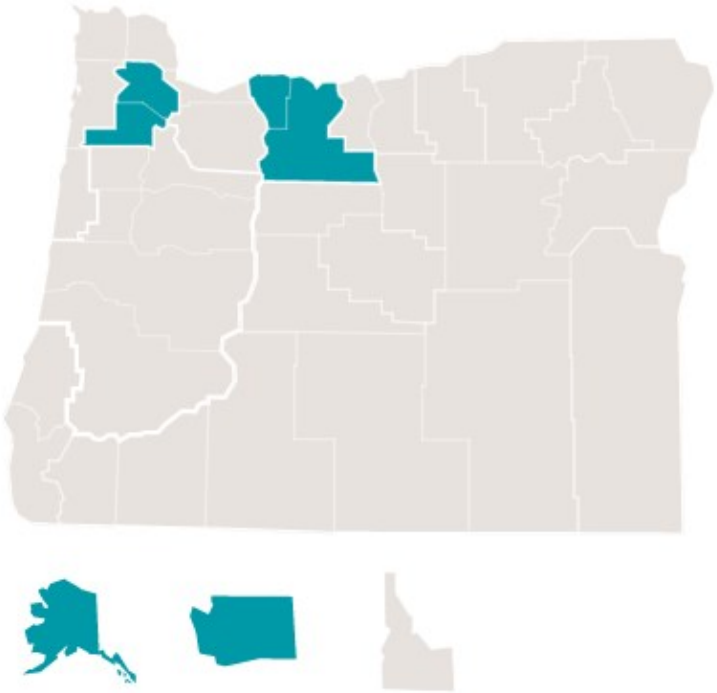

Kristina Swank
kristina.swank@modahealth.com
Serving Hood River, Wasco, Washington and Yamhill Counties, WA, AK and ZoomCare

Website updates

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Melissa Mayea
melissa.mayea@modahealth.com
Serving Benton, Douglas, Marion, Linn, Lane and Polk Counties

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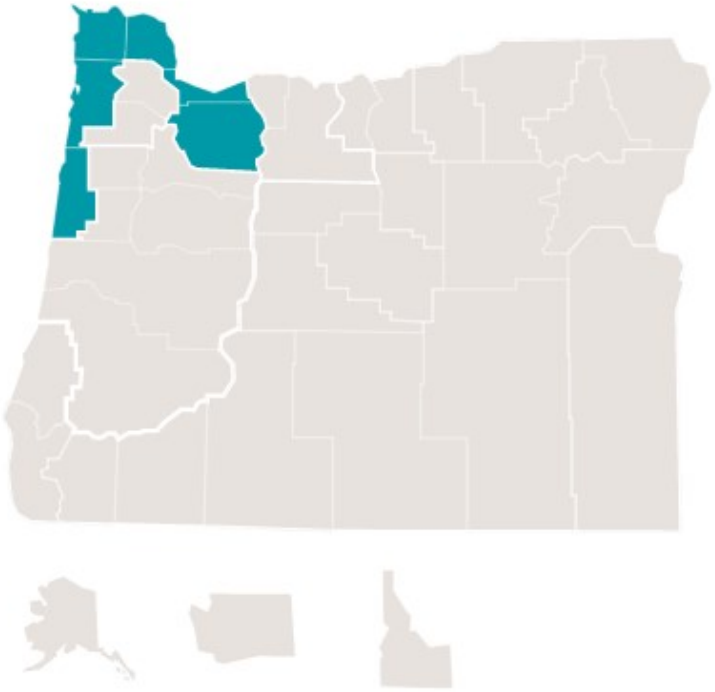


Brittany Davis
brittany.davis@modahealth.com
Serving Clackamas, Clatsop, Columbia, Lincoln, Multnomah, Tillamook Counties and OHSU

Remittance advice

- Claim specific overpayment deduction details have been added to the payment disbursement register (PDR) and Electronic Remittance Advice (ERA), including:

Original claim ID
Patient account number
Original paid date
Original paid amount

Overpayment amount
Previously recovered amount
Current recovered amount
Remaining overpayment amount

Overpayment Deductions Details 2

CLAIM	SUBSCRIBER ID	PATIENT	PATIENT ACCT	FOR SERVICES FROM TO	ORIGINAL DATE PAID	ORIGINAL CHECK #	ORIGINAL PAID AMOUNT	OVERPAYMENT AMOUNT	PREVIOUSLY RECOVERED	RECOVERED THIS CHECK	REMAINING OVERPAYMENT AMOUNT
809160000200	Z98765432	John Doe	2456A	0513 051317	06/27/2017	87545571	54.42	40.00	5.00	35.00	.00
TOTALS							54.42	40.00	5.00	35.00	.00

Primary Care Support

PCPCH Payments

- Synergy/Summit — Patient Centered Primary Care Home (PCPCH) Per Member Per Month (PMPM) payments.
  - Effective 1/1/2017 Oregon Health Authority expanded PCPCH recognition standards to 5 tiers.
    - Tier 1-$2.00
    - Tier 2-$4.00
    - Tier 3-$6.00
    - Tier 4-$8.00
    - Tier 5 (Five Star)-$12.00

    www.oregon.gov/oha/HPA/CSI-PCPCH/Pages/Become-Recognized.aspx

CPC+

Comprehensive Primary Care Plus (CPC+) is a national advanced primary care medical home model, led by CMS, that aims to strengthen primary care through:

- **Care Delivery Transformation** – Additional financial support, paid prospectively, enabling primary care practices to make fundamental changes to care delivery
  - Holistic, patient-centered care
- **Payment Reform**
  - Movement away from FFS reimbursement
- **Multipayer alignment on:**
    - Payment methodology
    - Metrics
    - Reporting

Provider reporting

Report Name	Purpose/Description	Frequency	Report Type
Member Roster	List of assigned members for each provider. Basic risk and utilization info.	Monthly	Clinical
High Risk Member Report	Detail on high risk members, such as diagnosis and treatment history	Monthly	Clinical
Chronic Condition Report	Detail on all members with a chronic condition (e.g. Diabetes, COPD, etc.)	Monthly	Clinical
High Risk Member Inpatient & ER	List of all Inpatient and Emergency Room visits for high-risk members	Monthly	Clinical
High Risk Member Claims Detail	List of all claims for high-risk members	Monthly	Clinical
High Risk Member Pharmacy	List of all prescriptions for high-risk members	Monthly	Clinical
Member Detail Report	Contains basic member demographic and contact information, including name, address, and phone number	Monthly	Clinical
Settlement Report	Calculates the amount of the risk-sharing bonus earned by each provider	Quarterly	Financial
Hospital Report	Displays utilization statistics such as admits/000, length of stay, readmissions, etc., for each hospital	Quarterly	Financial
Utilization Summary Report	Displays utilization statistics such as claims cost and count by category, PCP/Specialist utilization, generic drug utilization, etc., for each region	Quarterly	Financial

Reconsiderations and appeals

Provider reconsideration

A provider reconsideration is a pre-service request by a provider for Moda Health to reconsider a utilization management (UM) denial in light of new information sent to Moda by the provider.

- Submit new information verbally or in writing to demonstrate medical necessity for the requested service
- Must be submitted within 30 days of the pre-service denial

Provider reconsideration – same specialty request

A same specialty request is a pre-service request by a provider for Moda Health to have a same specialty provider reconsider a UM denial.

- Not necessary to submit new information
- Healthcare Services staff sends the request to Moda's medical consultant for like-specialty review

Peer-to-peer consultation

A peer-to-peer consultation is a conversation between the requesting provider and the Moda Health medical director who made a denial decision.

- Within 10 days of the pre-service denial
- With the medical director who did the initial denial
- May give new rationale for the requested service to support medical necessity

Provider appeals

Moda Health strives to resolve issues on initial contact whenever possible.

- Before entering the appeals process, please contact Moda Health's Medical Customer Service team.
- If the Customer Service team is unable to resolve the issue to your satisfaction, you have the right to dispute a decision and should take the steps outlined on the following slides.

Inquiries

The first time a request for review is submitted to the appeals team, it will always be considered an inquiry.

- The Moda Health Provider Appeals Unit will review the materials submitted

Moda Health's goal is to send written notification of its decision within 45 business days of receipt of the inquiry.

If the provider disagrees with the Moda Health determination in response to the inquiry, the provider may file a first-level provider appeal.

First-level and final appeals

First-level appeal

- The appeal will be reviewed by the director of Claims and the Moda Health medical director
- Moda Health's goal is to send a written notification of its decision within 45 business days of receipt of the appeal.

Final appeal

- If after inquiry and appeal determinations the appeal remains unresolved to the satisfaction of the provider, a final appeal may be made in writing to an appeals committee.
- A final appeal must be submitted within 60 days of the Moda Health determination on the appeal.

Submitting an inquiry or appeal

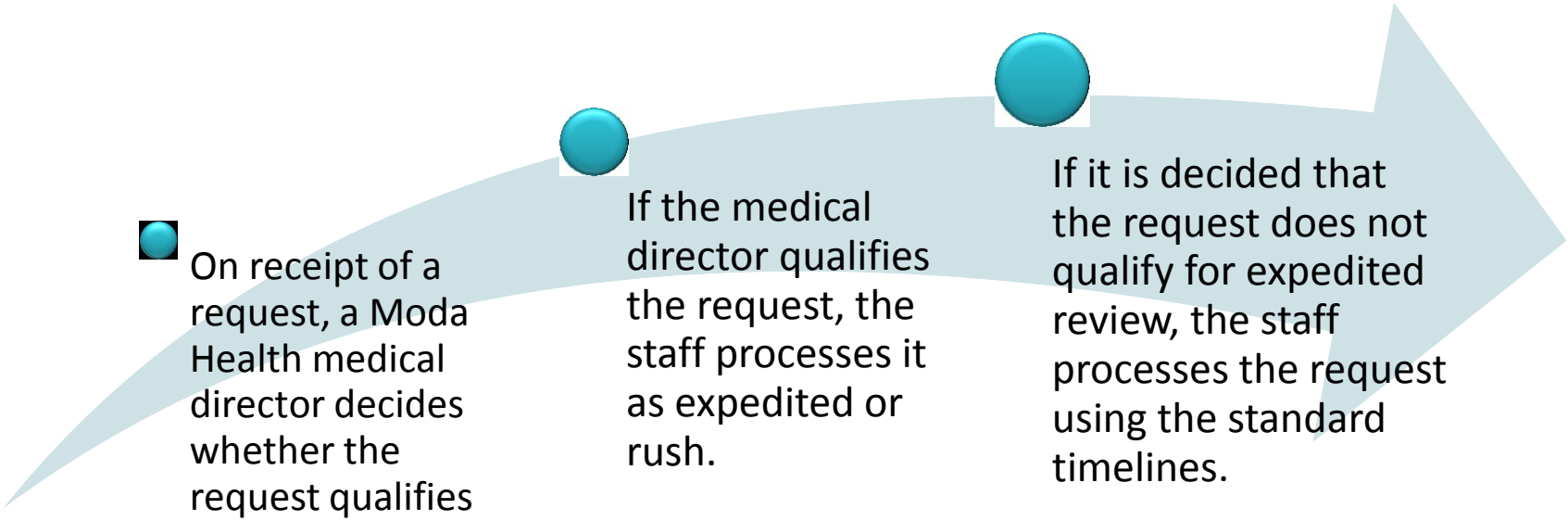
Inquiries and appeals must be submitted in writing and include the following information:

- **The provider's name**
- **The provider's Tax Identification Number**
- **Contact name, address and phone number**
- **Patient's name**
- **Moda Health member identification number**
- **Date of service and claim number or authorization number if no claim**
- **An explanation of the issue**
- **For claims involving coordination of benefits, the name and address of the primary carrier**
- **Inquiries and appeals should be submitted to:**

  Moda Health Plan, Inc.
  Provider Appeal Unit
  P.O. Box 40384
  Portland, OR 97240

Expedited or rush requests

An expedited or rush request is a pre-service appeal for medical care or treatment for which applying the time period for making a non-urgent care determination could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function.



Member appeal

A member appeal is a pre-service or post-service appeal initiated by a member regarding an adverse determination on an authorization request or a claim.

- A provider may file a pre-service member appeal on behalf of a member in writing
  - The Commercial or Marketplace member must complete a Moda Health Protected Health Information form.

HEDIS

HEDIS

What is HEDIS?

- HEDIS stands for Healthcare Effectiveness Data and Information Set. HEDIS was developed and is maintained by the National Committee for Quality Assurance (NCQA) whose vision is to transform healthcare quality through measurement, transparency and accountability.

HEDIS

Why is HEDIS important?

- HEDIS is a standardized set of metrics that evaluates clinical quality.
- Identifies and provides opportunities for improvement
- Consumers use the performance ratings to help make informed decisions regionally.
- NCQA accreditation is considered an important indicator of a plan’s ability to improve health.

HEDIS

- You can help facilitate the HEDIS improvement process by:
  - Providing appropriate care and documenting all care in the patients medical record accurately
  - Submitting accurate coding on all claims
  - Responding to our requests for medical records within 5-10 business days

HEDIS

- Receiving all requested medical records ensures that our results are an accurate reflection of care provided
- The medical records you provide also help us enhance member outreach with tools and reminders to assist the member in scheduling their annual screenings.
- We want to assist you with gaps-in-care.
- If you have questions or would like additional information, please feel free to contact us at hedis@modahealth.com or call 503-265-4702.

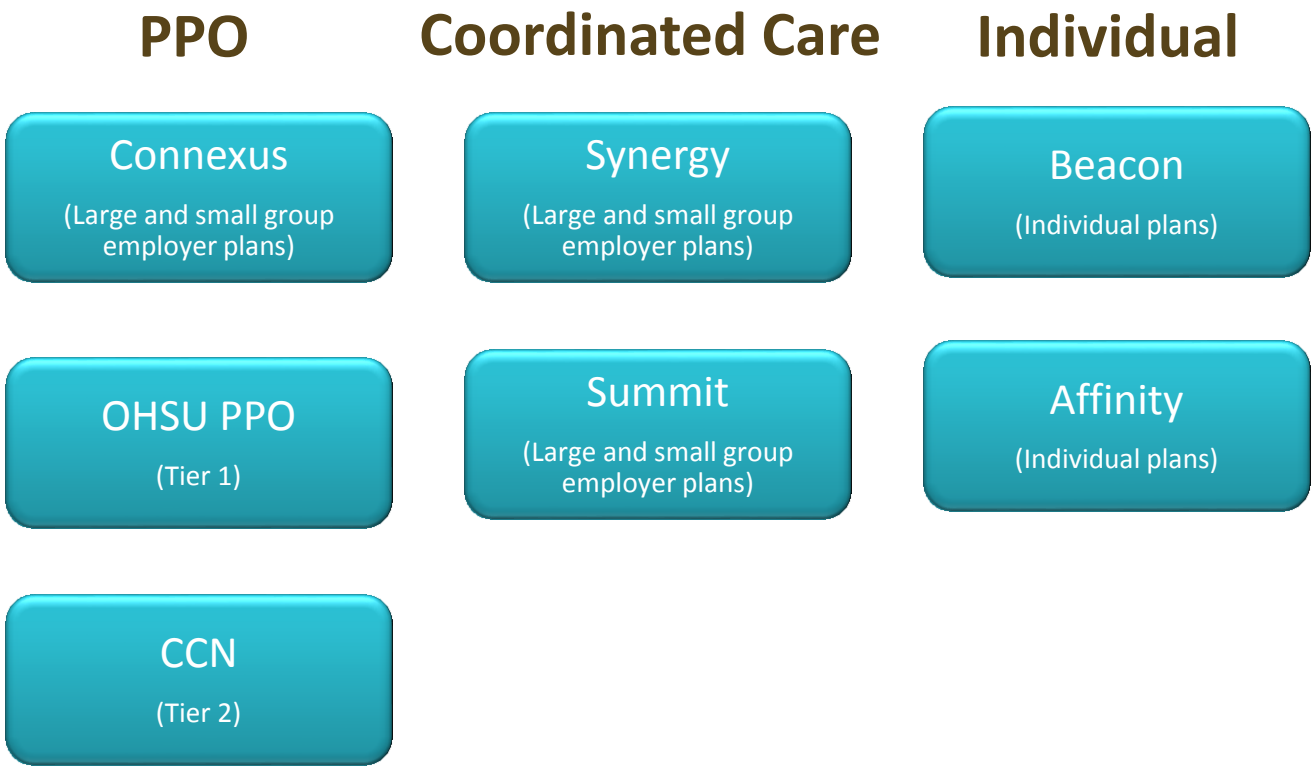
HEDIS

HEDIS Production Timeline

Commercial Updates

Commercial 2018 Benefit Changes

2018 commercial networks



2018 Employer group network lineup

Small group

- Connexus
  Statewide
- Synergy
  Western Oregon counties
- Summit
  Eastern Oregon counties

Large group

- Connexus
  Statewide
- Synergy
  Western Oregon counties
- Summit
  Eastern Oregon counties

Connexus Network

- Statewide PPO network
  - No PCP/Medical Home selection required
  - No referrals required
  - Member can see in-network providers in all counties in Oregon and some areas of Washington and Idaho.

Coordinated Care Model (CCM)

- CCM plans use the **Synergy** or **Summit** Network
- Synergy covers the following western and central Oregon counties:
  - Benton, Clackamas, Clark, Clatsop, Columbia, Crook, Deschutes, Hood River, Jackson, Jefferson, Josephine, Klamath, Lane, Lincoln, Linn, Marion, Multnomah, Polk, Tillamook, Wasco, Washington, and Yamhill
  - Available in Coos and Curry counties for OEBB members effective 10/01/17
- Summit covers the following eastern Oregon counties:
  - Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wheeler

Medical Homes

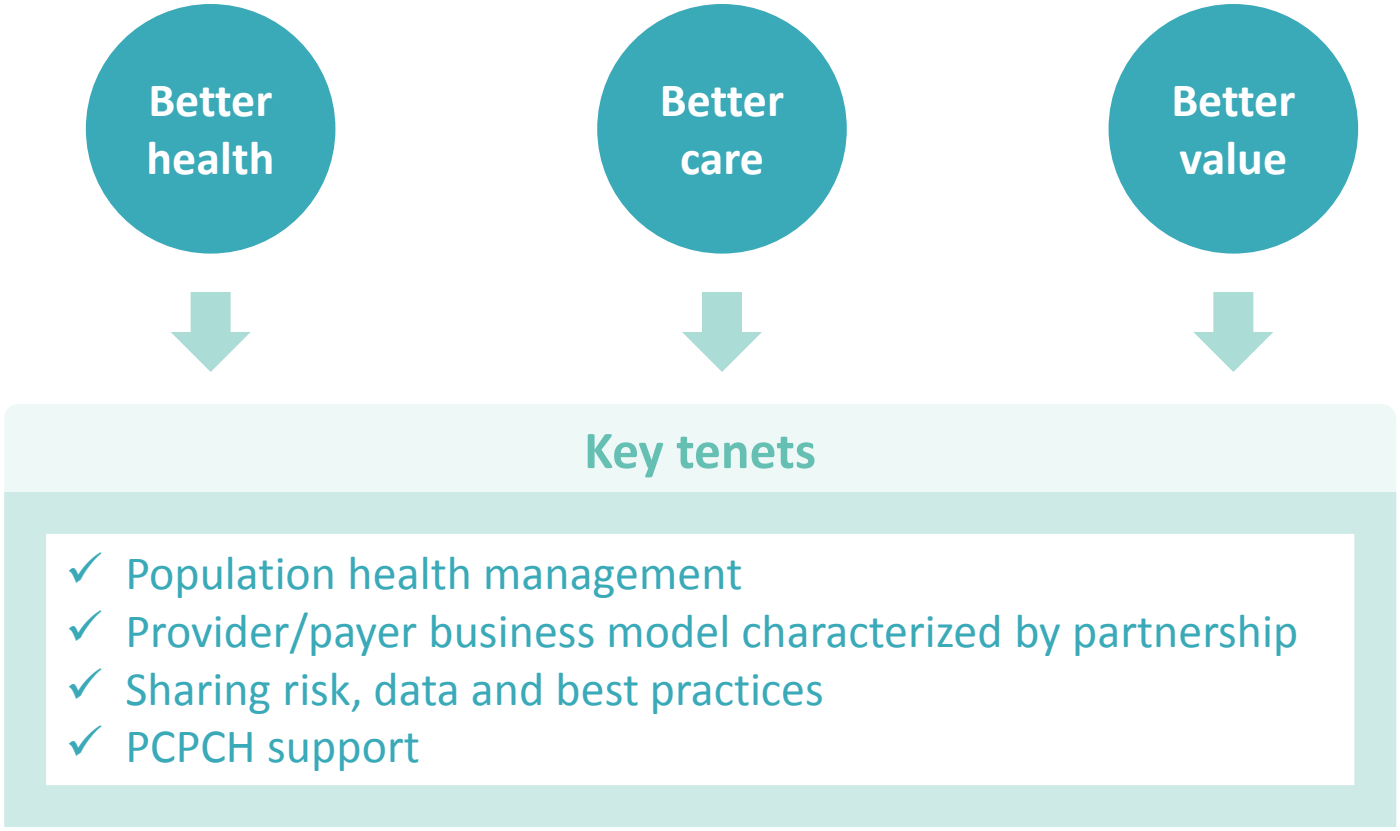
- CCM plans require selection of a Medical Home for each covered individual
  - Each family member may select a different Medical Home
- Must use selected Medical Home for **primary care** in order to receive in-network benefits
  - Primary care includes doctors, nurse practitioners & physician assistants who practice:
    - Internal medicine
    - Family medicine
    - General practice
    - Geriatric medicine
    - Pediatrics
    - Obstetrics/gynecology or women's health
- Primary care received ***outside*** of your selected Medical Home will be processed & paid as ***out-of-network***

Overview of CCM vs. PPO

CCM Plans	PPO Plans
Utilize Moda's narrower networks: **Synergy** - western and central Oregon **Summit** – eastern Oregon	Utilize **Connexus** Network – Moda's largest network option offered statewide
All enrolled members must select/use Medical Home for all primary care services	Members do NOT select a Medical Home: more freedom to see any provider/clinic
Specialists and other providers/facilities must be in Synergy or Summit Network; they do NOT need to be within the Medical Home	Specialists and other providers/facilities must be in the Connexus Network
Referrals are **NOT** required to see specialists	
Lower copays for pharmacy expenses; accrues toward medical plan's OOP limit	Higher copays for pharmacy expenses; accrues toward Max Cost Share

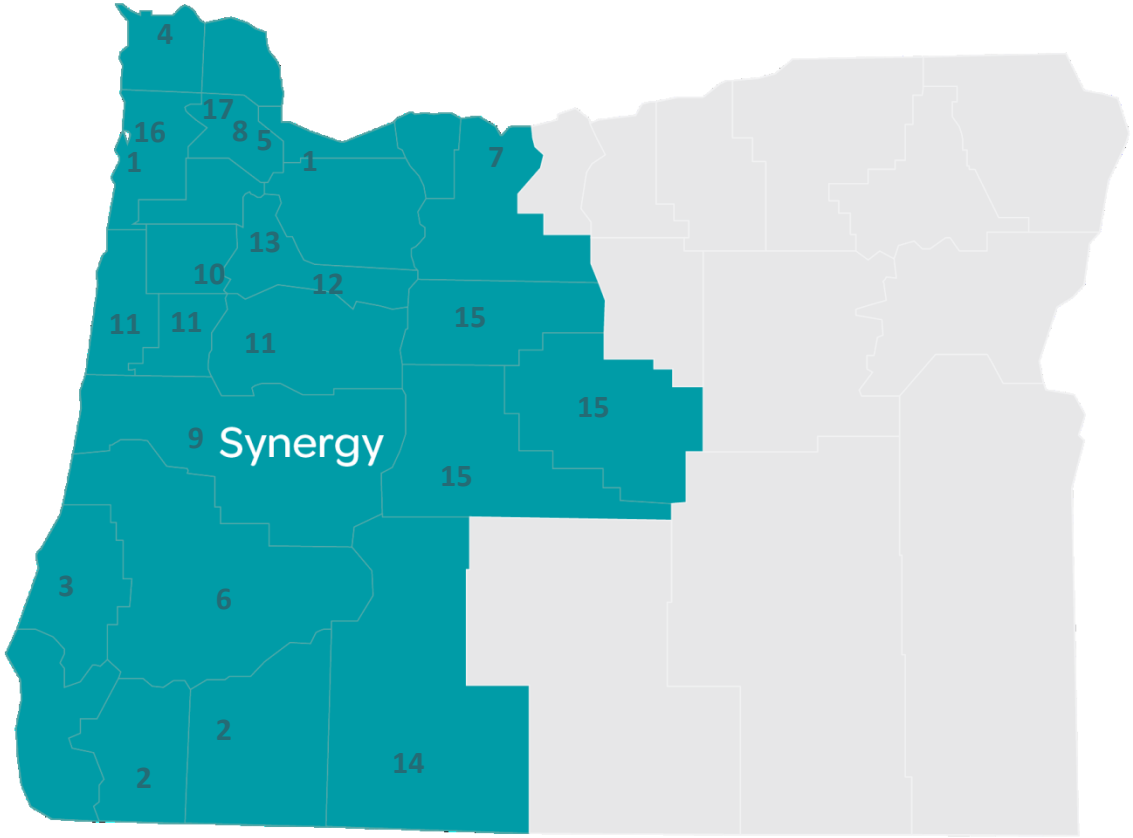
Synergy/Summit networks

Partnership between Moda Health and Providers to achieve Triple Aim goals



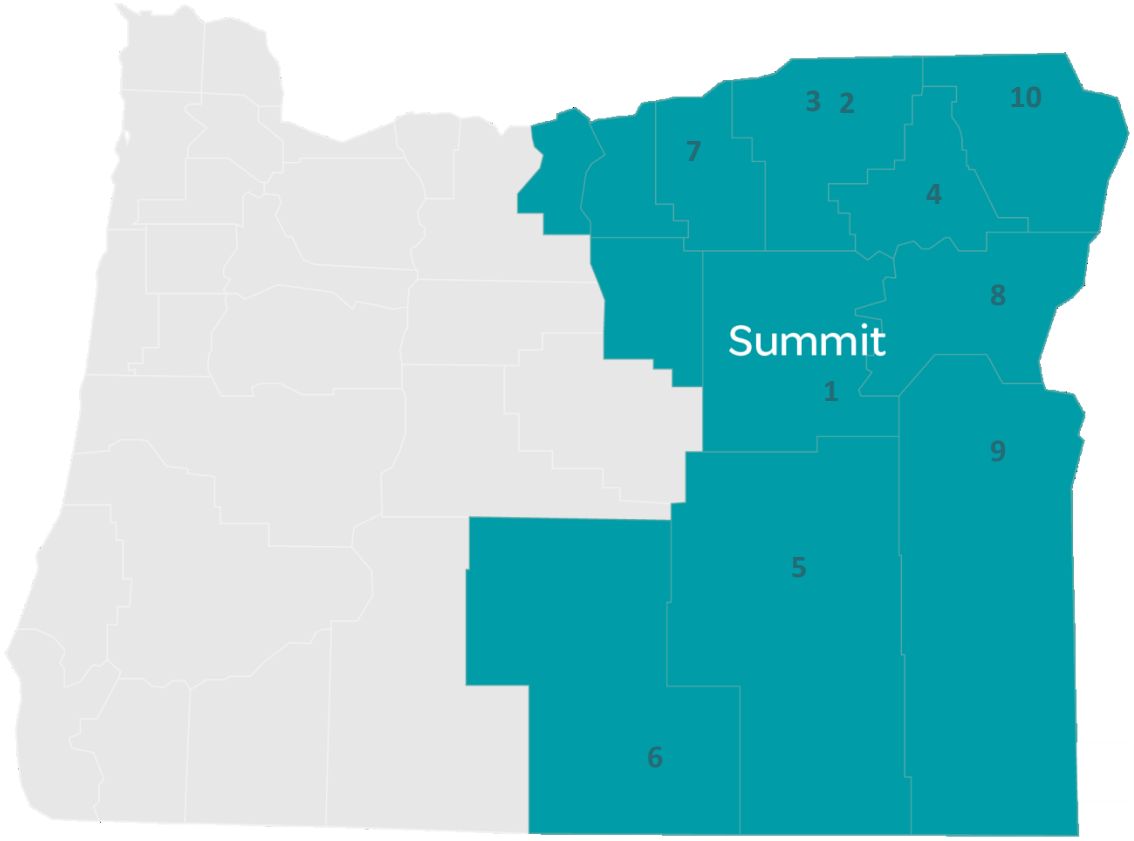
Synergy Network

1. Adventist Health
2. Asante
3. Bay Area Hospital
4. Columbia Memorial Hospital
5. Legacy Health
6. Mercy Medical Center
7. Mid-Columbia Medical Center
8. Oregon Health & Science University (OHSU)
9. PeaceHealth
10. Salem Health
11. Samaritan Health Services
12. Santiam Hospital
13. Silverton Hospital
14. Sky Lakes Medical Center
15. St. Charles Health System
16. Tillamook Regional Medical Center
17. Tuality Healthcare



Summit Network

1. Blue Mountain Hospital District
2. CHI St. Anthony Hospital
3. Good Shepherd
4. Grande Ronde Hospital
5. Harney District Hospital
6. Lake Health District
7. Morrow County Health District
8. Saint Alphonsus – Baker City
9. Saint Alphonsus – Ontario
10. Wallowa Memorial Hospital



OHSU PPO & CCN Networks

- OHSU PPO
  - Tier 1 benefit plan for OHSU employees only with statewide participation determined by OHSU (closed panel)
- CCN
  - Tier 2 benefit plan for OHSU employees only with participation in select counties determined by OHSU (closed panel):
    - Clackamas, Deschutes, Marion, Multnomah, Polk, Washington and Yamhill counties

2018 Individual Network lineup

Beacon

Select Western Oregon counties

- Clackamas
- Clatsop
- Columbia
- Coos
- Curry
- Hood River
- Jackson
- Josephine
- Marion
- Multnomah
- Polk
- Tillamook
- Wasco
- Washington
- Yamhill

Affinity

Central & Eastern Oregon counties

- Baker
- Crook
- Deschutes
- Grant
- Gilliam
- Harney
- Jefferson
- Klamath
- Lake
- Lane
- Malheur
- Morrow
- Sherman
- Umatilla
- Union
- Wallowa
- Wheeler

Beacon Network

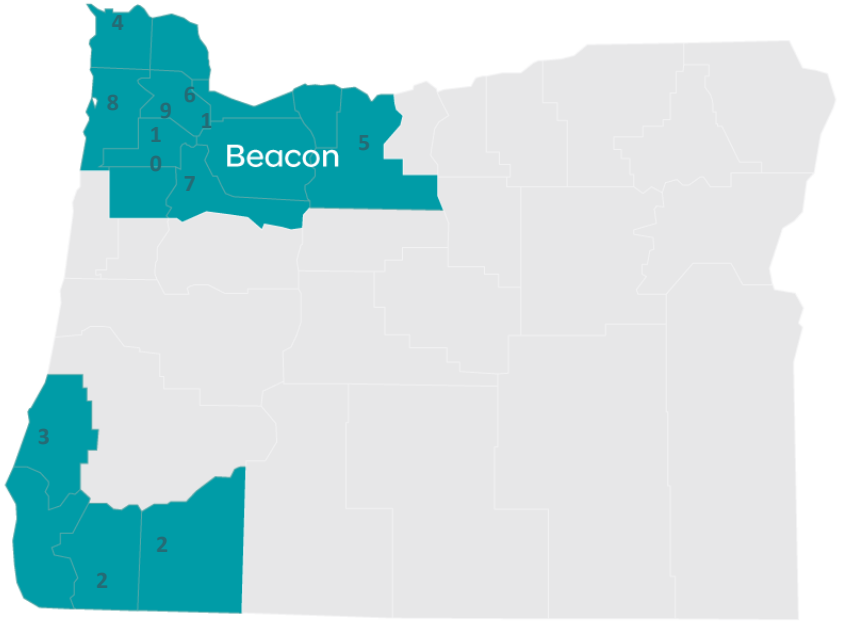
Effective Jan. 1, 2018

What is different?

- Expanded service area to include Tillamook county
- Clinically integrated network, which includes 12 health system partners and their referring providers
- Expanded plan design options (2 bronze, 3 silver and 4 gold)
- PCP selection is required.

Beacon Network

1. Adventist Health
2. Asante
3. Bay Area Hospital
4. Columbia Memorial Hospital
5. Mid-Columbia Medical Center
6. Oregon Health &
   Science University (OHSU)
7. Salem Health
8. Tillamook Regional Medical Center
9. Tuality Healthcare
10. Willamette Valley Medical Center



Affinity Network

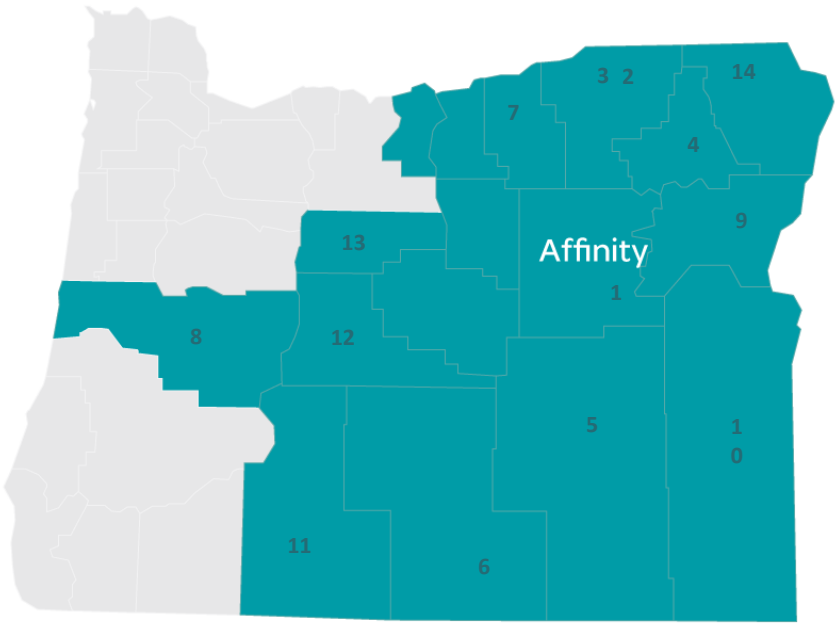
Effective Jan. 1, 2018

What is different?

- Expanded to include Crook, Deschutes, Jefferson, Klamath and Lane counties
  Primarily mirrors EOCCO & Summit Network geography
- Simplified plan design options (1 bronze, 1 silver and 1 gold)
- PCP selection is required.

Affinity Network

1. Blue Mountain Hospital District
2. CHI St. Anthony Hospital
3. Good Shepherd
4. Grande Ronde Hospital
5. Harney District Hospital
6. Lake Health District
7. Morrow County Health District
8. PeaceHealth
9. St. Alphonsus – Baker City
10. St. Alphonsus – Ontario
11. Sky Lakes Medical Center
12. St. Charles Health System – Deschutes
13. St. Charles Health System – Jefferson
14. Wallowa Memorial Hospital



OEBB

- Synergy and Summit coordinated care plan benefits remain the same for 2018.
  - Alder plan no longer available in Coos & Curry counties
  - Synergy is available in Coos & Curry counties
- Copays remain the same for 2018.
- Bariatric surgery (gastric sleeve and Roux-en-Y) will be covered for any dependent over the age of 18 effective Oct. 1
- Vision has removed 12 month waiting period for non-preventive services.

PEBB

- Site of Care program implemented 1/1/2018
- Implementing a closed formulary, which will exclude some medications

OEBB & PEBB

- Introducing the Health through Oral Wellness initiative. This is available to all contracted dental providers.
  - Members could be eligible for additional dental benefits (cleanings, fluoride, tobacco cessation) after completing a screening tool
- Virtual care (telehealth) solution
  - Partnering with OHSU to provide web-based telehealth services
  - Available to OEBB and PEBB members effective 10/17/2017
  - OEBB — $10 (deductible does not apply) for Alder, Birch, Cedar and Dogwood plans; $10 after deductible for Evergreen plans; PEBB — $0

OHSU PPO

- No major changes to plan design for 2018
  - CCN still remains Tier 2 benefits for 2018
- Deductibles will increase by $25 (single) and $75 (family) across all plans
- OOP maximums will increase $25 (single) and $50 (family) across all plans
- Pharmacy OOP maximum will increase to $1,600 (single) and $2,700 (family)

OHSU PPO

- Massage therapy, 60 visits per year, medical necessity will be required **after 12 visits (this is the change)**. In-network providers only (eviCore does not authorize)
- eviCore: imaging only, no ultrasounds
- Fertility: adding coverage for treatment, $5,000 lifetime limit. **Benefit only at OHSU** (University Fertility Consultants)

Salem Health

- In 2017, Salem Health has three benefit plans to choose from (PPO, HDHP and the MHP (Synergy), in 2018 they will have two (MHP/Synergy and the HDHP). It is expected that the 5,000 or so members that are currently on the PPO today will transition to the Synergy plan.
- eviCore: imaging only

Individual/exchange plans

- Increasing out of network accumulators (from 2x to 4x)
- Applying the deductible to more pharmacy tiers on silver plans
- Replacing one existing Gold and Silver plan with OV copay centric versions
- Required compliance change — required to offer Bronze Standard HDHP plan by DFR, adding Bronze OV copay plan to replace previous bronze plan

Medicare updates

Medicare Advantage 2018 benefit changes

Medicare updates

Moda Health PPO

Benefit changes

Medicare updates – PPO

Moda Health PPO changes

Medicare covered hearing exam copay:

2017: $35 copay INN; $35 copay OON

2018: $25 copay INN; $25 copay OON

Medicare updates – PPO

Moda Health PPO (PPO)	In-Network	Out of Network
Annual out of pocket maximum	$3,400	
Annual medical deductible	$0	
Primary care provider	$20	$20
Special office visit	$35	$35
Inpatient hospital (days 1-5)	$250	$350
Outpatient surgery (per stay)	$200	$300
Lab services	$0	
X-ray, CT, MRI, PET, etc.	20%	
Routine vision exam every two years	$35	
Skilled Nursing Facilities	$0 per day (days 1-20) $100 per day (days 21-100)	
Part B drugs	20%	
Durable Medical Equipment	20%	
Diabetic supplies	$0	
Ambulance (each one way trip)	$100	
Urgent care centers	$35	
Emergency Room	$65	

Medicare updates

Moda Health PPORX

Benefit changes

Medicare updates - PPORX

Moda Health PPORX changes

Medicare covered hearing exam copay:

2017: $35 copay INN; $50 copay OON

2018: $30 copay INN; $50 copay OON

Medicare (Part C) deductible change:

2017: $125 deductible

2018: $100 deductible

Medicare updates – PPORX

Moda Health PPORX (PPO)	In-Network	Out of Network
Annual out of pocket maximum	$3,400	
Annual medical deductible	**$100**	
Primary care provider	$25	$40
Special office visit	$35	$50
Inpatient hospital (days 1-5)	$295	$400
Outpatient surgery (per stay)	$295	30%
Lab services	$0	
X-ray, CT, MRI, PET, etc.	20%	30%
Routine vision exam every two years	$35	
Skilled Nursing Facilities	$0 per day (days 1-20), $100 per day (days 21-100)	
Part B drugs	20%	30%
Durable Medical Equipment	20%	30%
Diabetic supplies	$0	
Ambulance (each one way trip)	$250	
Urgent care centers	$35	
Emergency Room	$65	

Medicare updates

Moda Health HMO

Benefit changes

Medicare updates - HMO

Moda Health HMO changes

Medicare covered hearing exam copay:

2017: $35 copay INN; $50 copay OON

2018: $25 copay INN; N/A copay OON

Medicare (Part C) deductible change:

2017: $110 deductible

2018: $85 deductible

Removal of all POS OON benefits

Medicare updates – HMO

Annual out of pocket maximum	3,400
	In-Network
Annual medical deductible	$85
Primary care provider	$25
Special office visit	$35
Inpatient hospital	$300 (days 1-5) $0 (days 6+)
Outpatient surgery (per stay)	10% ASC 20% Hospital
Lab services	$0
X-ray, CT, MRI, PET, etc.	20%
Routine vision exam annually	$35
Skilled Nursing Facilities	$0 per day (days 1-20) $100 per day (days 21-100)
Part B drugs	20%
Durable Medical Equipment	20%
Diabetic supplies	$0
Ambulance (each one way trip)	$250
Urgent care centers	$35
Emergency Room	$65

Medicare updates – HMO

HMO Care Coordination

- Members must select a Primary Care Physician (PCP) for this plan.
- The plan will also require a PCP referral for the following services:
  - Chiropractic services
  - Outpatient rehabilitation
    - Cardiac and pulmonary rehab services
    - Physical Therapy, Occupational Therapy, and Speech Language Pathology services
- Specialist services
- Podiatrist services
- Other health care professional services

Medicare updates – HMO

HMO Care Coordination

- Vision services
- Hearing services/exams
- Referral exceptions:
  - Emergencies
    - Urgently needed care when network is not available (out of network)
    - Out of area dialysis services (should contact the plan)
    - Moda Health HMO authorized use of out of network providers

Medicare updates

Medicare supplemental benefits

Supplemental benefits

Moda Health Extra Care

Available at an additional $12 premium per month and includes non-Medicare covered services such as:

- Chiropractic
- Naturopathic
- Acupuncture
- Hearing services
- Vision hardware

50% coinsurance for services up to a $500 maximum benefit per year

Silver & Fit® Exercise & Healthy Aging Program

The Silver & Fit® benefit is available on both PPO and PPORX plans.

Flexible benefit

- Fitness club or exercise center
- Group fitness classes for older adults
- Home fitness program
- Up to two home fitness kits per benefit year

Silver Slate quarterly newsletter

$0 copayment

2018 Part D

2018 Part D Changes

Drug Benefits – PPORX (PPO)

• Deductible	$120
• Tier 1 (preferred generic)	$2
• Tier 2 (Non-preferred generic)	$20
• Tier 3 (preferred brand)	$45
• Tier 4 (Non-preferred Brand)	$100 (change from 50% coinsurance)
• Tier 5 (Specialty Tier)	30% coinsurance (1 month supply)

- Member cost-share represents a 31 day supply
- Mail order 3x cost-share for a 93 day supply

- 2018 coverage gap
  - Generic – member pays 44% of plans cost
  - Brands – member pays 35% of the negotiated cost
  - Closed formulary – PDF available on our website

2018 Part D Changes

Drug Benefits – HMO

• Deductible	$120
• Tier 1 (preferred generic)	$4
• Tier 2 (Non-preferred generic)	$10
• Tier 3 (preferred brand)	$45
• Tier 4 (Non-preferred Brand)	$95
• Tier 5 (Specialty Tier)	30% coinsurance (1 month supply)

- Member cost-share represents a 31 day supply
- Mail order 3x cost-share for a 93 day supply

- 2018 coverage gap
  - Generic – member pays 44% of plans cost
  - Brands – member pays 35% of the negotiated cost
  - Closed formulary – PDF available on our website

Medication Therapy Management Program

Members are eligible for participation if they meet all of the following criteria:

- Have two or more of the following chronic conditions:
  - Diabetes
  - High Blood Pressure
  - Asthma
  - Osteoarthritis
  - CHF (Chronic Heart Failure)
  - High Cholesterol
  - Depression
  - COPD
  - HIV/AIDS
- Take five or more medications
- Have drug costs that total $3,919 or more annually

Seasonal flu

- New CPT code 90682 effective for claims with DOS 7/1/2017 and after
  - May be given once per influenza season
  - Administration code remains G0008
  - Diagnosis code remains Z23
- Covered when provided by an in-network provider or pharmacy

Plan Directed Care

- Ensures Medicare Advantage Plan members receive medically necessary services that are covered by their Moda Health Medicare Advantage health plan
- **Referrals to non-participating provider**s – Participating providers referring Medicare Advantage members to non-participating physicians, providers or agencies must obtain prior authorization for certain procedures and services as outlined in the Moda Health Medicare Advantage agreement.

Compliance attestation

- Contracted providers must submit attestation to their compliance with the following requirements:
  - Compliance Program, Policies & Procedures, Code of Conduct
  - Fraud, Waste & Abuse Training
  - Reporting Mechanisms & Disciplinary Standards
  - Sub-Delegation Contracts
  - Off-shore Activities
  - OIG and GSA screening

Provider directory outreach

- CMS mandates that Medicare Advantage plans verify provider demographic information on a quarterly basis.
- Types of information we are required to validate include:
  - Practicing location
  - Accepting new Medicare patients status
  - Phone number
  - Provider specialty
- Roster outreach and phone validation

Medicaid/EOCCO

EOCCO

- Started in September 2012 with 1,200 members
- 12 Counties make up our coverage area: Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, and Wheeler
- As of June 2017, EOCCO just over 46,000 members
- September 2017 is EOCCO 5 year anniversary

Contacting EOCCO

Moda Customer Service: 888-788-9821
Claims, benefits, general questions

EOCCO Pharmacy Customer Service: 888-474-8539
Pharmacy benefits

GOBHI: 800-493-0040
Behavioral health and chemical dependency benefits

Mid-Columbia Council of Governments: 877-875-4657
Non-emergency Medical Transportation

Noah Pietz, Medicaid Services Coordinator
noah.pietz@modahealth.com
503-265-4786

- www.eocco.com

Contacting Moda Health

& Holiday Closure Information

Contact information

Medical Provider Configuration (demographic updates)

providerupdates@modahealth.com

Medical Provider Relations or Contracts

providerrelations@modahealth.com

Moda Customer Service

Phone 503-243-3962

medical@modahealth.com

Prior Authorizations

Phone 503-243-4496

Toll-free 800-258-2037

Credentialing

Phone 855-801-2993

credentialing@modahealth.com

Moda Health holiday closures

2017

Thanksgiving:	Thursday, Nov. 23
Day after Thanksgiving:	Friday, Nov. 24
Christmas:	Monday, Dec. 25
Day after Christmas:	Tuesday, Dec. 26

2018

New Year’s Day:	Monday, Jan. 1
Martin Luther King Jr:	Monday, Jan. 15
Memorial Day:	Monday, May 28
Independence Day:	Wednesday, July 4
Labor Day:	Monday, Sept. 3

Be better