moda

2018 Provider Workshop

Presented by Moda Health

Welcome

Portland metro area

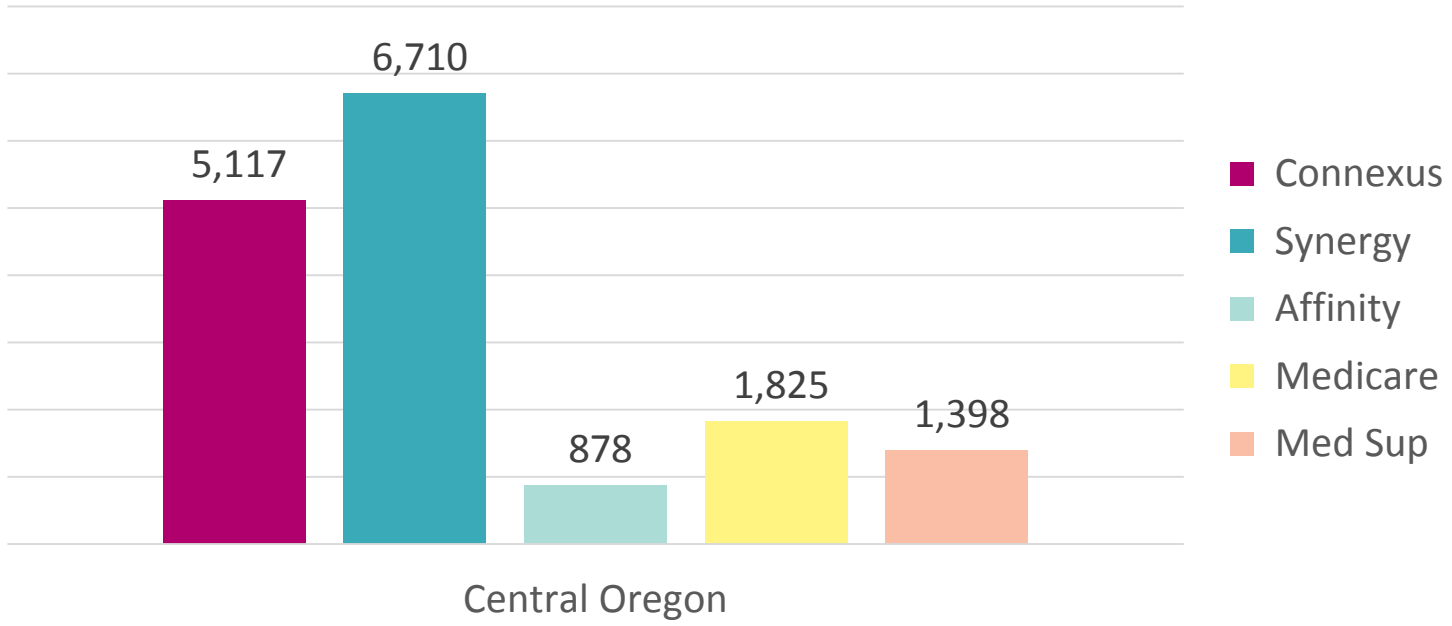
Agenda

- Organizational updates and processes
- Commercial updates
- Medicare Advantage updates

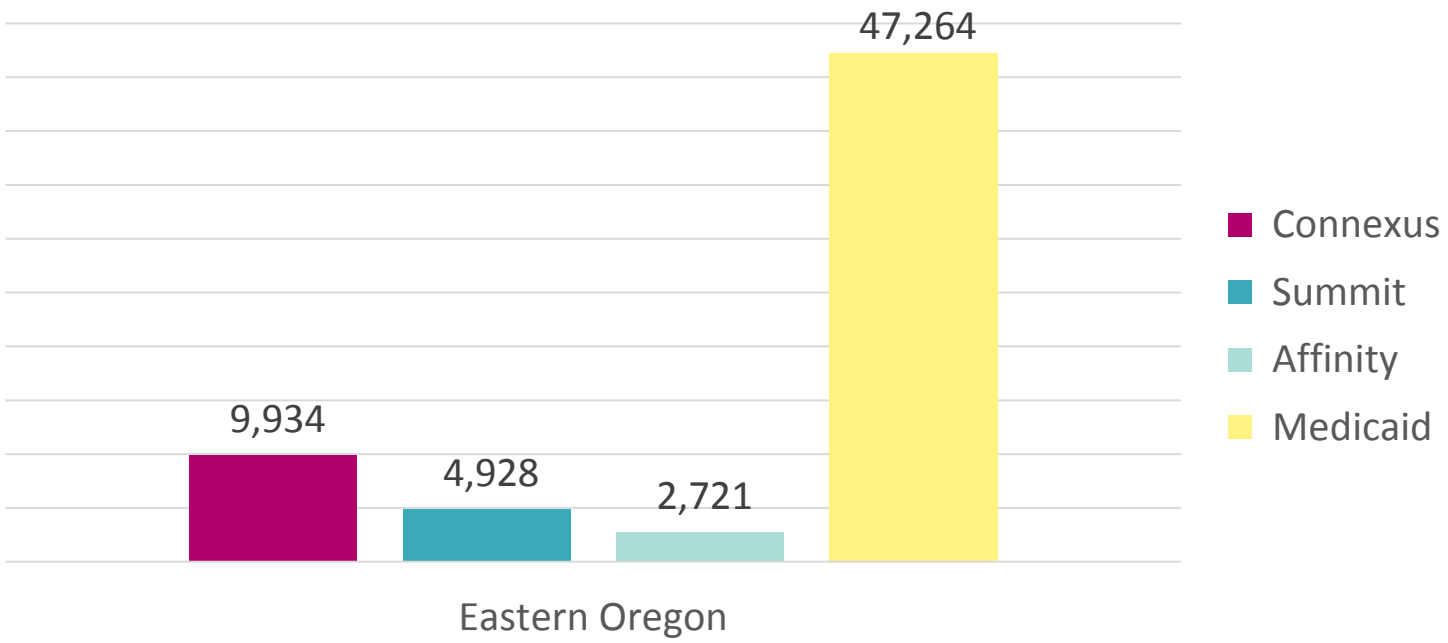
Organizational updates

Membership

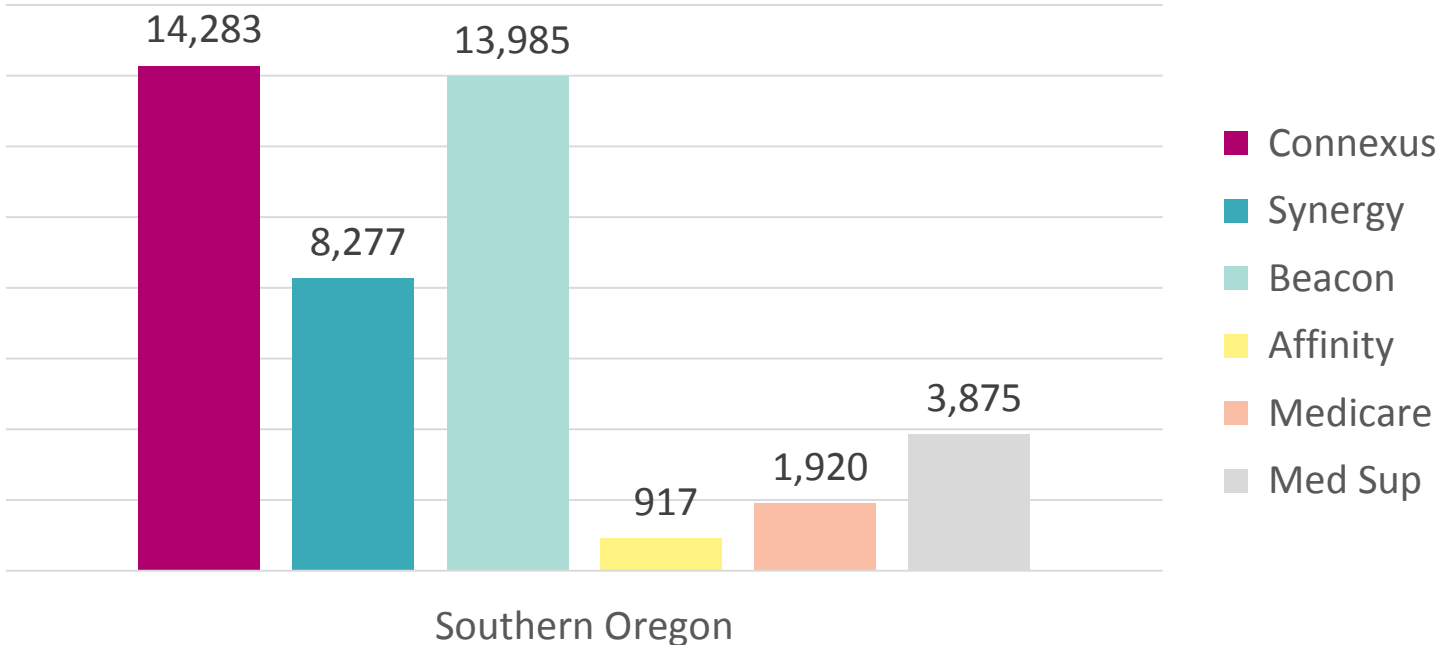
Membership
Central Oregon



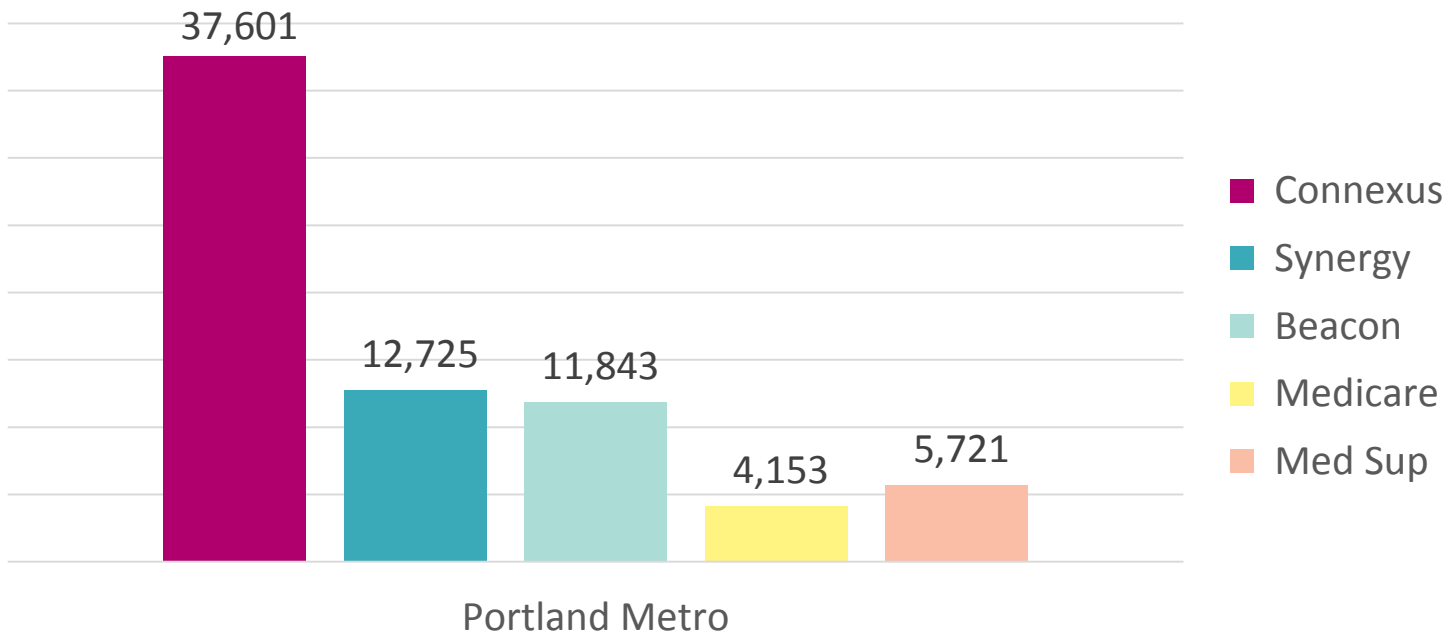
Membership
Eastern Oregon



Membership
Southern Oregon

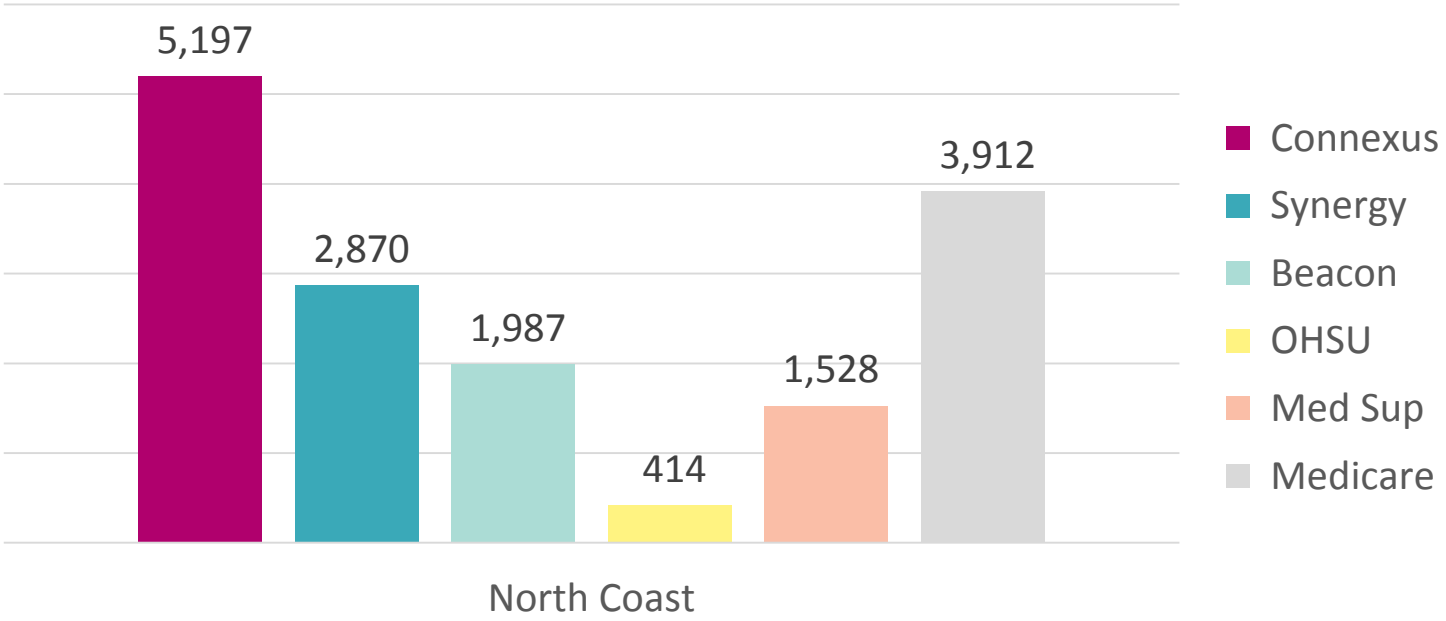


Membership
Portland metro



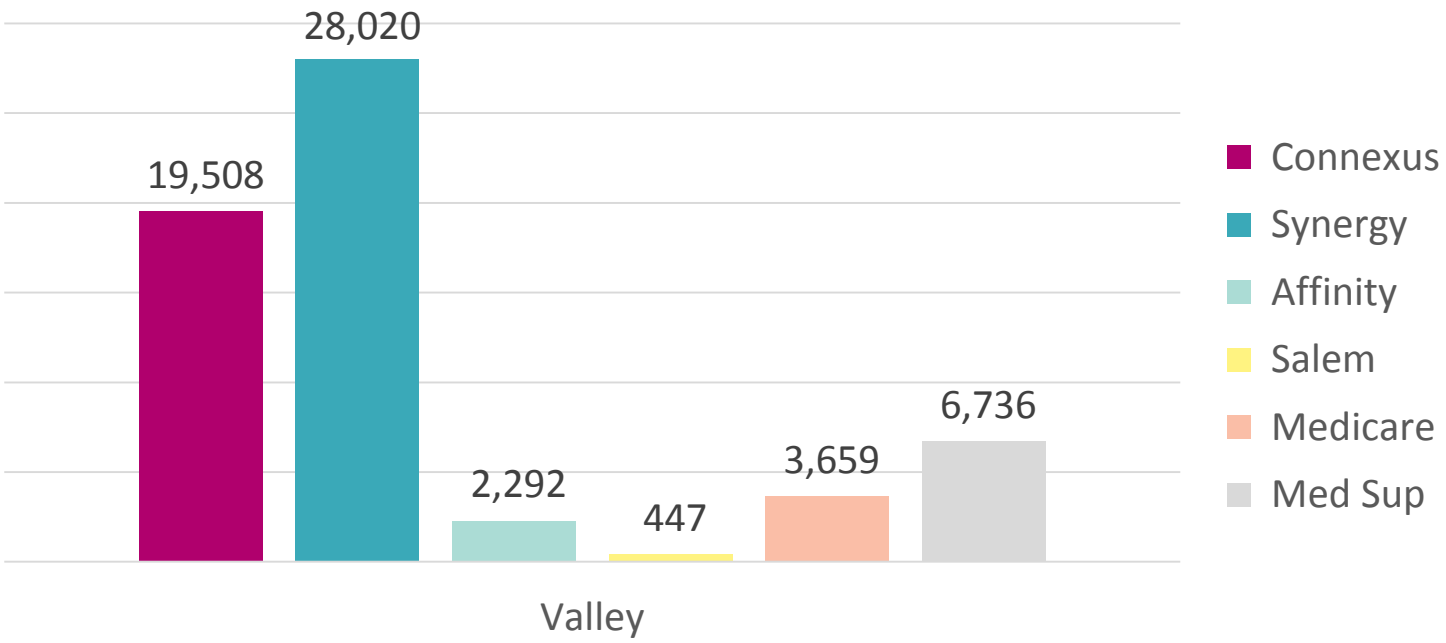
Membership

North coast



Membership

Valley



HEDIS

HEDIS

Why is HEDIS important?

- HEDIS is a standardized set of metrics created by NCQA 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

How can I help?

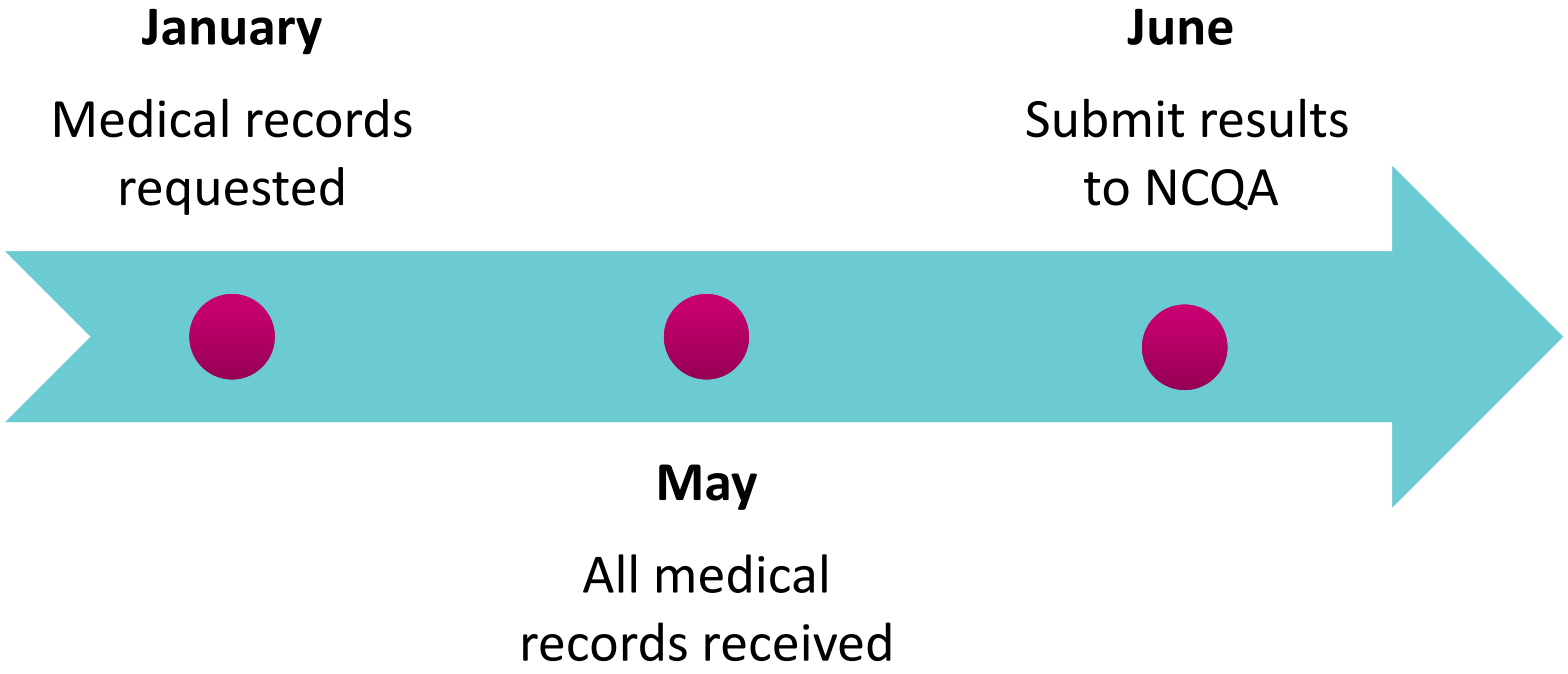
- Document all care provided in the patients medical record accurately
- Submit accurate coding on all claims
- Respond to medical record requests within five – 10 business days

What else do I need to know?

- Responding to requests for medical records ensures that our results are an accurate reflection of care provided
- Medical records you provide also help us conduct member outreach with tools and reminders for annual screenings
- If you have questions or would like additional information, please email hedis@modahealth.com or call 503-265-4702

HEDIS

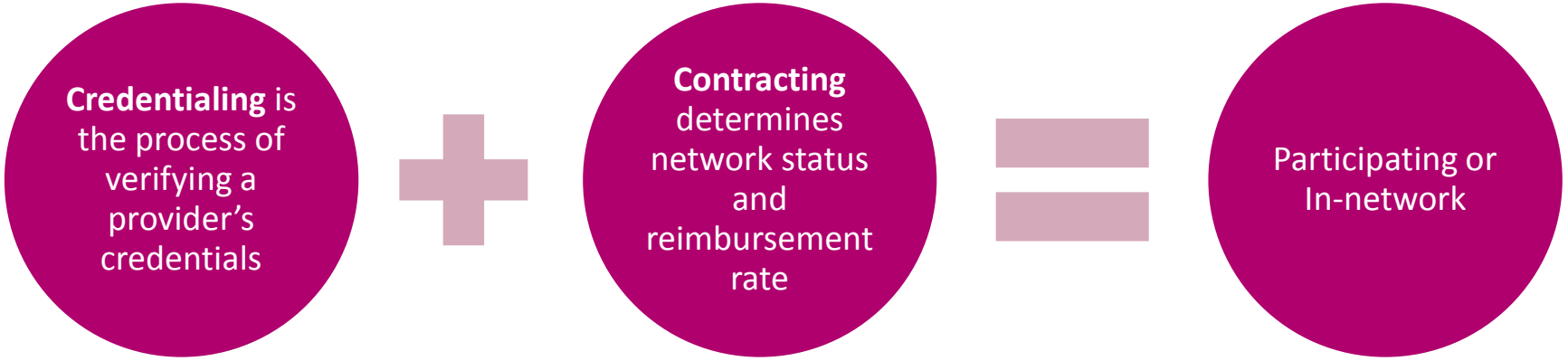
Production timeline



Credentialing with Moda Health

Credentialing with Moda Health

Credentialing vs. contracting



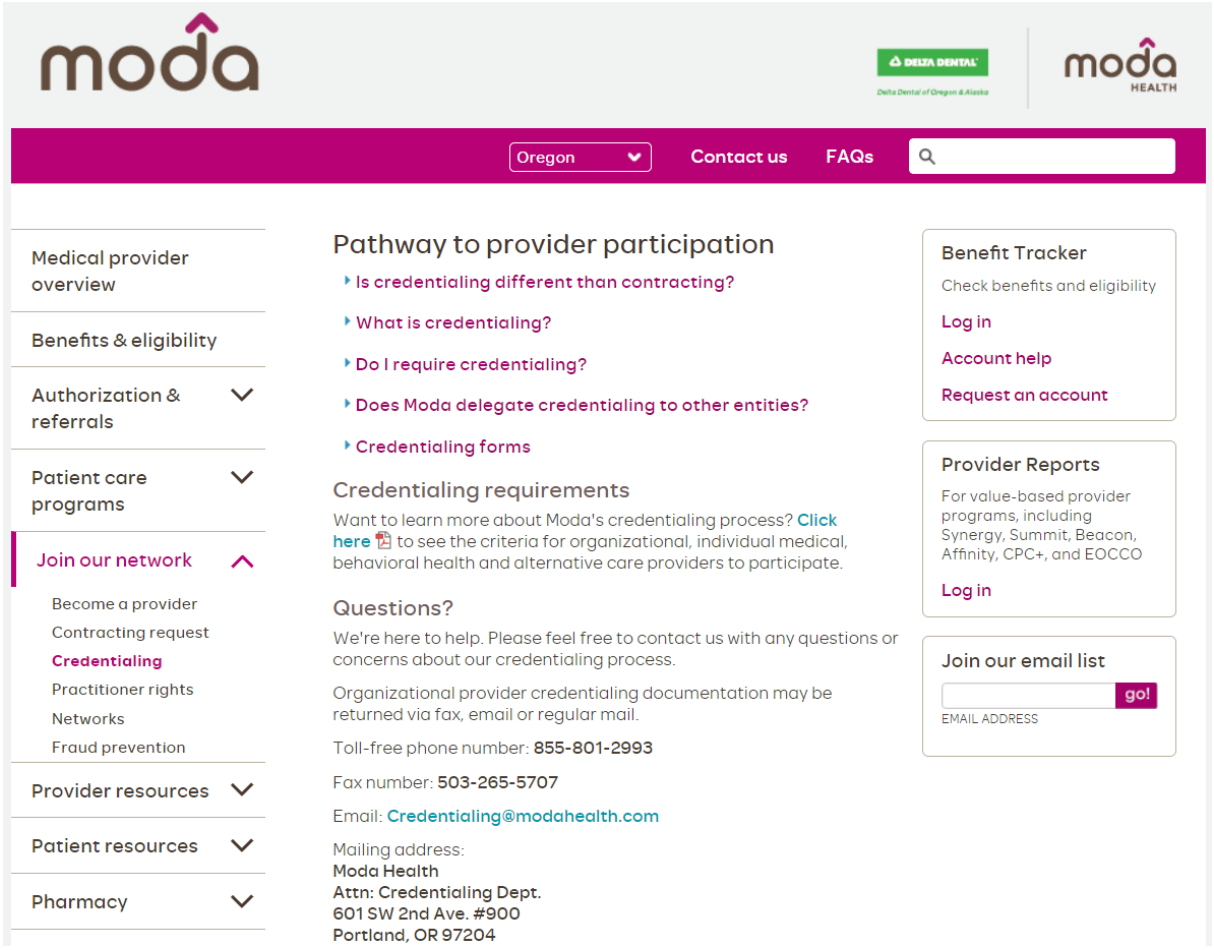
Credentialing with Moda Health

Special processes

- Locum tenens
  - Requires formal notification
  - Limited to 90 consecutive days
- Hospital-based providers
  - Requires formal notification
  - Limited to providing in-patient services only
- Forms for locum tenens and hospital-based providers can be found on Moda's credentialing page

Credentialing with Moda Health

Online resources



Credentialing with Moda Health
Oregon Common Credentialing Program

- As of July 2018, the Oregon Health Authority (OHA) has decided to suspend the Oregon Common Credentialing Program (OCCP)
- Providers will continue to submit credentialing applications directly to Moda Health or through their IPA, when applicable
- The OHA will continue to manage the Oregon Practitioner Credentialing Application (OPCA) and review annually for updates
- www.oregon.gov/oha/HPA/OHIT-OCCP/Pages/index.aspx

Claims

Claims

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
- Address for corrected claim submission:

  P.O. Box 40384

  Portland, OR 97240

Claims

Timely filing

- Timely filing guidelines are as follows:

- Commercial plans
  - Initial claim must be submitted within 12 months from date of service
  - Corrected claim must be received 18 months from the last date of adjudication.
    - Up to 30 months for COB

- Medicare plans
  - Initial claim must be submitted within 12 months from date of service
  - Corrected claim must be received 12 months from the last date of adjudication.

Claims
Optum iCES

- Clinical edit enhancements went live 7/29/2018
- Multiple payment reductions
    - Endoscopy
    - Diagnostic imaging
    - Therapy
    - Cardiovascular
    - Ophthalmology
- Anesthesia modifiers
- LCD/NCDs for Medicare Advantage

TruHearing

Commercial benefits

TruHearing

- Hearing aid benefits only available through TruHearing
- Participating Commercial providers must join the TruHearing network
- TruHearing handles verification of benefits and processing of claims

Commercial benefits

TruHearing

- Benefit package includes:
  - Three fitting and adjustment office visits
  - 48 free batteries per aid
  - Three-year repair warranty
  - Three-year loss and damage warranty
  - 45-day money-back guarantee
- To join the TruHearing network or for transactional needs:
  - 866-581-9462
  - provider.relations@truhearing.com

Healthcare Services

Healthcare Services

Reminders

- Moda Health medical necessity criteria is posted on the Moda Health website at modahealth.com
- Expedited requests — Medicare definition: *Choose ONLY if you are attesting that waiting for a decision under the standard time frame could place the enrollee's life, health or ability to regain maximum function in serious jeopardy. Completed within 72 hours of receipt.*

Healthcare Services

Prior authorizations

- How to determine that a service requires prior authorization
  - Review Referral and Authorization guidelines based on line of business
  - Review “Always Not covered” list
  - modahealth.com/medical/referrals/

- If a service requires prior authorization
  - Review Moda Health’s prior authorization contact information to determine where the request should be submitted
  - For services requiring prior authorization through Moda Health, complete the Referral and Authorization form (commercial or Medicare Advantage), or contact Medical Intake
  - modahealth.com/pdfs/referral_form.pdf

Healthcare Services

Genetic testing

- All genetic testing requires prior authorization
- 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
- Genetic testing medical necessity criteria can be found here: modahealth.com/pdfs/med_criteria/GeneticTesting.pdf

Healthcare Services

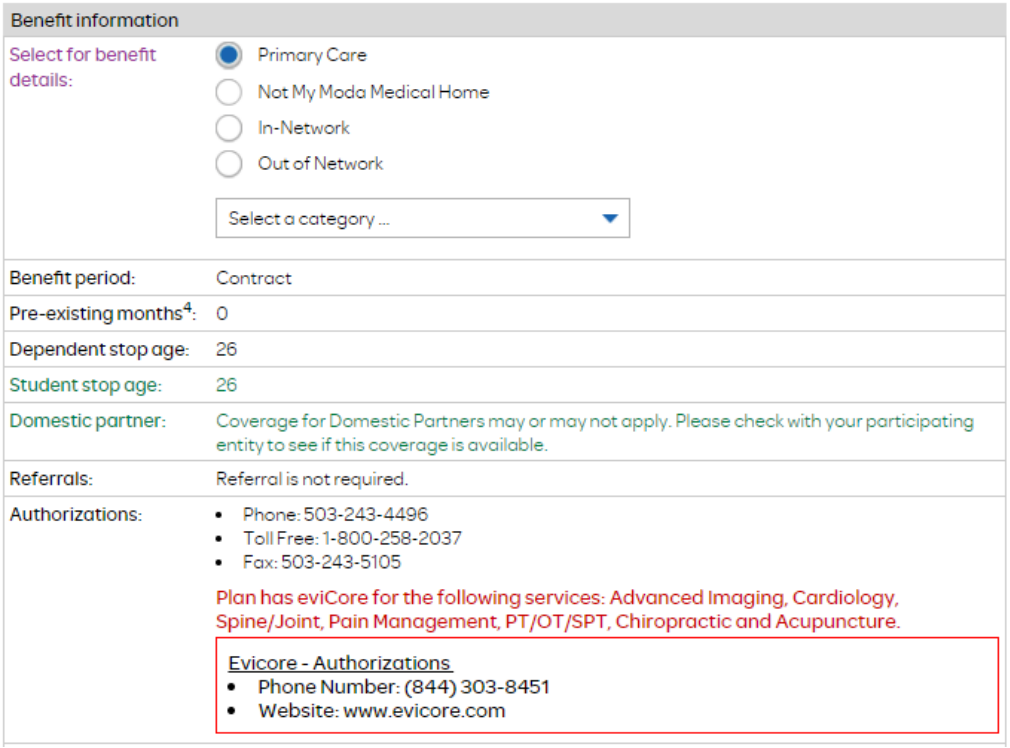
eviCore

- eviCore reviews authorization requests for the following services:
  - Advanced imaging
  - Musculoskeletal therapies
  - Pain management
  - Spine and joint surgery
- Services that require prior authorization through eviCore are listed on our website modahealth.com/medical/utilizationmanagement.shtml

Healthcare Services

eviCore

- Check Benefit Tracker to determine if member's plan utilizes eviCore and for what services
  - Can be found on main benefit page in red



Benefit information	
Select for benefit details:	◉ Primary Care ○ Not My Moda Medical Home ○ In-Network ○ Out of Network Select a category ...
Benefit period:	Contract
Pre-existing months[4]:	0
Dependent stop age:	26
Student stop age:	26
Domestic partner:	Coverage for Domestic Partners may or may not apply. Please check with your participating entity to see if this coverage is available.
Referrals:	Referral is not required.
Authorizations:	• Phone: 503-243-4496 • Toll Free: 1-800-258-2037 • Fax: 503-243-5105 Plan has eviCore for the following services: Advanced Imaging, Cardiology, Spine/Joint, Pain Management, PT/OT/SPT, Chiropractic and Acupuncture. Evicore - Authorizations • Phone Number: (844) 303-8451 • Website: www.evicore.com

Healthcare Services

eviCore

- As of 8/17/2018, urgent requests may be submitted via web portal
  - Supporting medical records must be uploaded during the case build for review
- Users may now upload up to five documents online
- Provider-at-a-Glance summary now available

Healthcare Services

eviCore

- eviCore has clinical worksheets and guidelines available to assist you with submission of authorizations online
- The clinical guidelines provide prerequisites required before a service will be authorized, e.g. needing to try physical therapy before having surgery

Healthcare Services

Magellan Rx

- Magellan Rx reviews authorization requests for specialty injectable medications performed in:
  - an outpatient facility
  - a patient's home
  - a physician's office

New medications added to the PA list effective Oct. 1, 2018

Effective Oct. 1, 2018	
J3490	Akynzeo
J3590	Crysvita
J3490	Durolane
J3590	Illumya
J3490	Trivisc
J3590	Trogarzo
J7321	Visco - 3

Healthcare Services

Drug Wastage Program

- Effective Oct. 1, 2018, the Provider Administered Drug Program that is managed by Magellan Rx will be enhanced to help provide the most efficient dosage for select buy-and-bill drugs

Program goals

Healthcare Services

Drug Wastage Program

- **About the program**
  - When authorization is requested for these drugs, a recommendation to adjust dosages to the nearest vial size combination will be made
  - The online portal (or intake specialist, if phoning in the prior authorization) will display the most efficient vial size combinations that should be utilized
  - Acceptance of these recommendations is completely voluntary, and adjustments should be made at the ordering physician's discretion
- modahealth.com/medical/injectables/

Healthcare Services

Infusion Site of Care

- Applies to select infused specialty medications
- A complete list of medications can be found at www.modahealth.com/medical/siteofcare.shtml

New medications added to the
Site of Care list effective Oct. 1, 2018

Effective Oct. 1, 2018	
J2350	Ocrevus
J3590	Trogarzo

Healthcare Services

Infusion Site of Care

- Coram
  - "Preferred" home infusion provider in most cases
  - Able to service membership/demographics quickly
    - Support all ZIP codes in scope
    - Service within 24-48 hours of receiving a completed order
  - Some plans, i.e., OEBB have zero cost sharing at Coram (deductible and coinsurance waived)

- OHSU
  - OHSU prescribers are directed to OHSU Home Infusion Services

Healthcare Services

CoverMyMeds

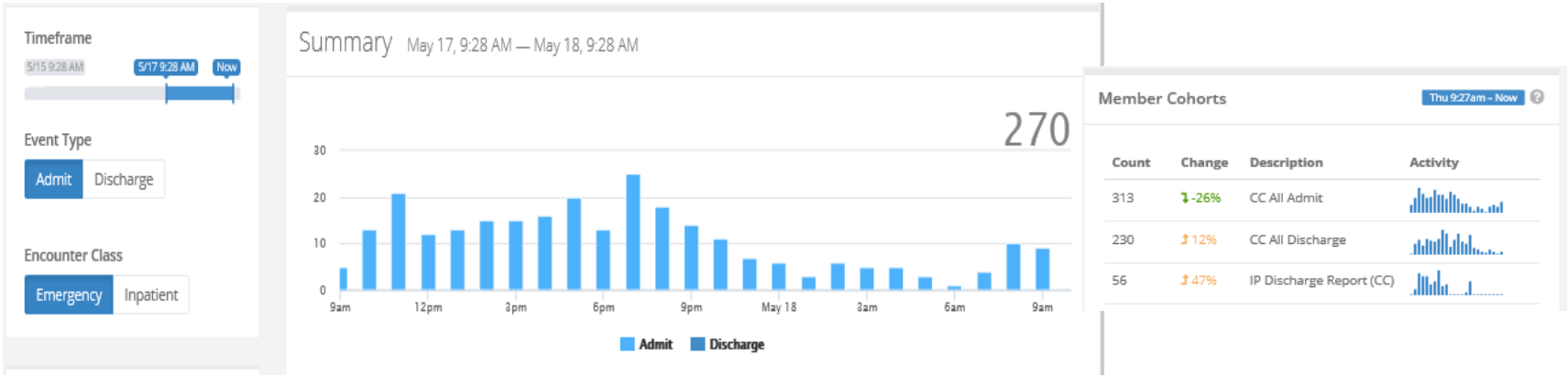
- Partnership with CoverMyMeds to process electronic prior authorization (ePA) requests for medications covered under a member's pharmacy benefit
- This free online tool is integrated with all health plans and most large EHR systems
- Allows for faster determination, often in real time
- Automatic PA renewal setup for recurring medications
- This does not replace Magellan Rx for injectable medications or Ardon Health for specialty pharmacy
- covermymeds.com

Healthcare Services

PreManage

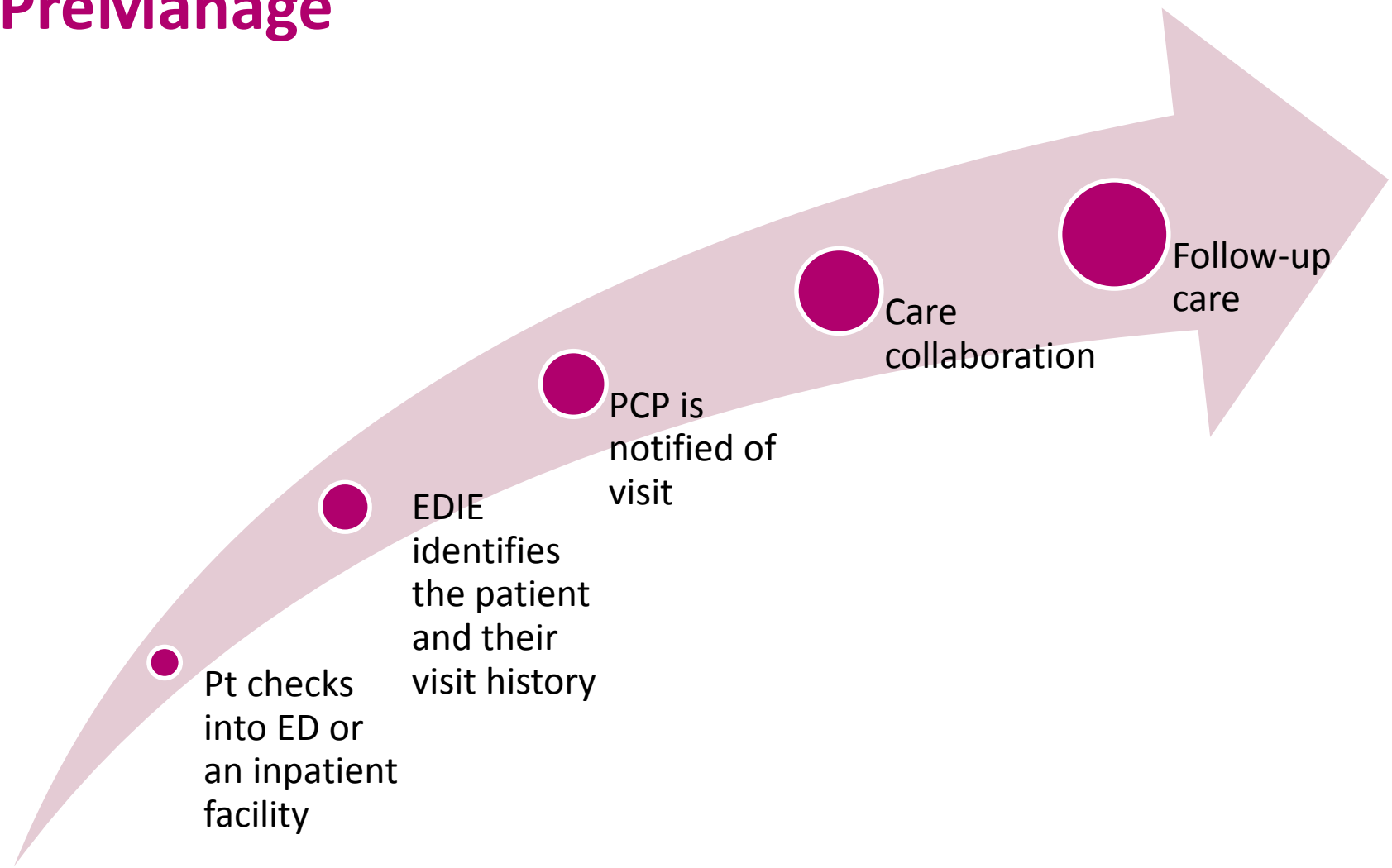
- PreManage is an EDIE-based shared communication tool sending real-time alerts from ED admits directly to your EHR

- What are the benefits?
  - Faster care by engaging in effective communication and collaboration with other providers
  - Access the necessary information needed in one system
  - Available for all patients within your clinic



Healthcare Services

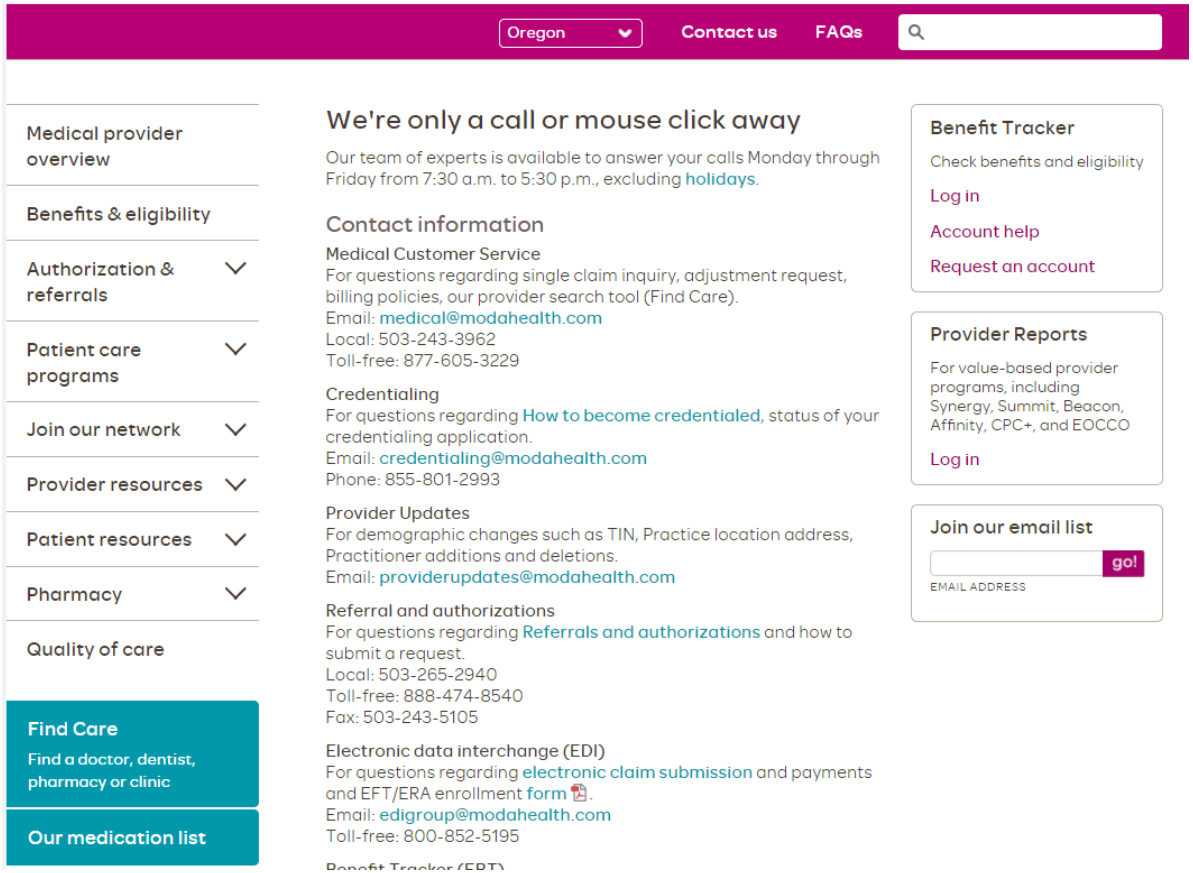
PreManage



Working with Moda Health

Working with Moda Health

To find out who to contact for the most commonly requested inquiries, please visit modahealth.com/medical/contactus.



Working with Moda Health

- **Customer Service** — For questions regarding single claim inquiry, adjustment request, billing policies and our provider search tool, Find Care
  - Email: medical@modahealth.com
  - Local: 503-243-3962
  - Toll-free: 877-605-3229
- **Credentialing** — For questions regarding how to become credentialed and the status of your credentialing application
  - Email: credentialing@modahealth.com
  - Phone: 855-801-2993

Working with Moda Health

- **Provider updates** — For demographic changes (excluding TIN changes), practice address updates, practitioner additions and deletions
  - Email: providerupdates@modahealth.com

- **Electronic data interchange (EDI)** — For questions regarding electronic claim submission and payments, and EFT/ERA enrollment form
  - Email: edigroup@modahealth.com
  - Toll-free: 800-852-5195

Working with Moda Health

- **Contract/fee schedule requests and TIN changes**
  - Email: providerrelations@modahealth.com

- **Referrals and authorizations** — For questions regarding referrals and authorizations, and how to submit a request
  - Local: 503-265-2940
  - Toll-free: 888-474-8540
  - Fax: 503-243-5105

Value-based provider reports

Value-based provider reports
Clinical and financial reporting

- We offer clinical and financial performance reports for our value-based networks, including member rosters, chronic condition, ER/IP notifications and settlement reports
- To request provider report portal access, email riskrptquestions@modahealth.com with:
  - First and last name
  - Email address
  - Role
  - Choice of clinical, financial or both types of reports

Value-based provider reports

Data sharing

- Expanding data sharing arrangements with Synergy Network and participating CPC+ track I and II primary care practices
- Supports a collaborative approach for gaining insight into the health needs of patients and Moda Health members, by focusing on quality measurement, and clinical and claim data integration
- For more information on participating in Moda Health's Value-Based Data Sharing Program, data submission formatting guideline questions and to start sharing data, please email valuebaseddatasharing@modahealth.com

Reconsiderations and appeals

Reconsiderations and appeals

Provider reconsiderations

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 Health 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

Reconsiderations and appeals

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 Health's medical consultant for like-specialty review

Reconsiderations and appeals

Peer-to-peer consultation

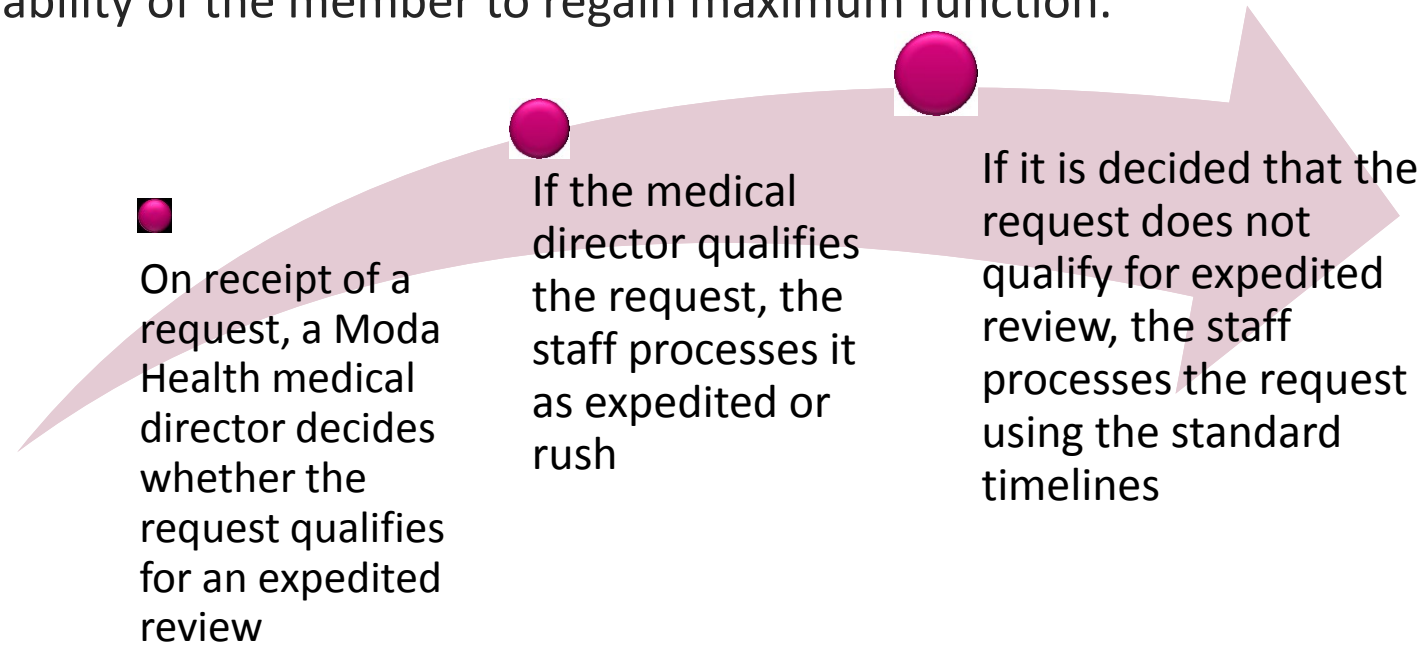
A peer-to-peer consultation is a conversation between the requesting provider and the Moda Health medical director who made a denial decision.

- 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

Reconsiderations and appeals

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.



Reconsiderations and appeals

Provider appeals

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

First level

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

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

Reconsiderations and appeals

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

Reconsiderations and appeals

Medical record requests

Moda Health may request medical records and supporting statements to make decisions on the preceding requests.

Healthcare providers and health plans meet the definition of a covered entity under the Health Information Portability Act and may share information for treatment purposes without a signed patient authorization

Documentation is necessary to determine the following:

- Medical necessity or appropriateness of a service or supply to be covered
- The standard and/or quality of care or services provided

If the documentation is not provided within the timeframe specified, coverage may be denied

Reconsiderations and appeals

Member appeals

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.

Commercial networks

2019 Commercial networks

Commercial updates

2019 Commercial networks

PPO	Value Based Employer group	Value Based Individual
Connexus (Large and small group employer plans)	Synergy (Large and small group employer plans)	Beacon (Individual plans)
OHSU PPO (Tier 1)	Summit (Large and small group employer plans)	Affinity (Individual plans)
CCN (Tier 2)		Cornerstone (Individual plans)

Commercial PPO networks

Commercial updates

Commercial PPO networks

- Connexus
  - 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

Commercial updates
OHSU PPO and CCN networks

- OHSU PPO
  - Tier 1 benefit plan for OHSU employees only with statewide participation determined by OHSU (closed panel)

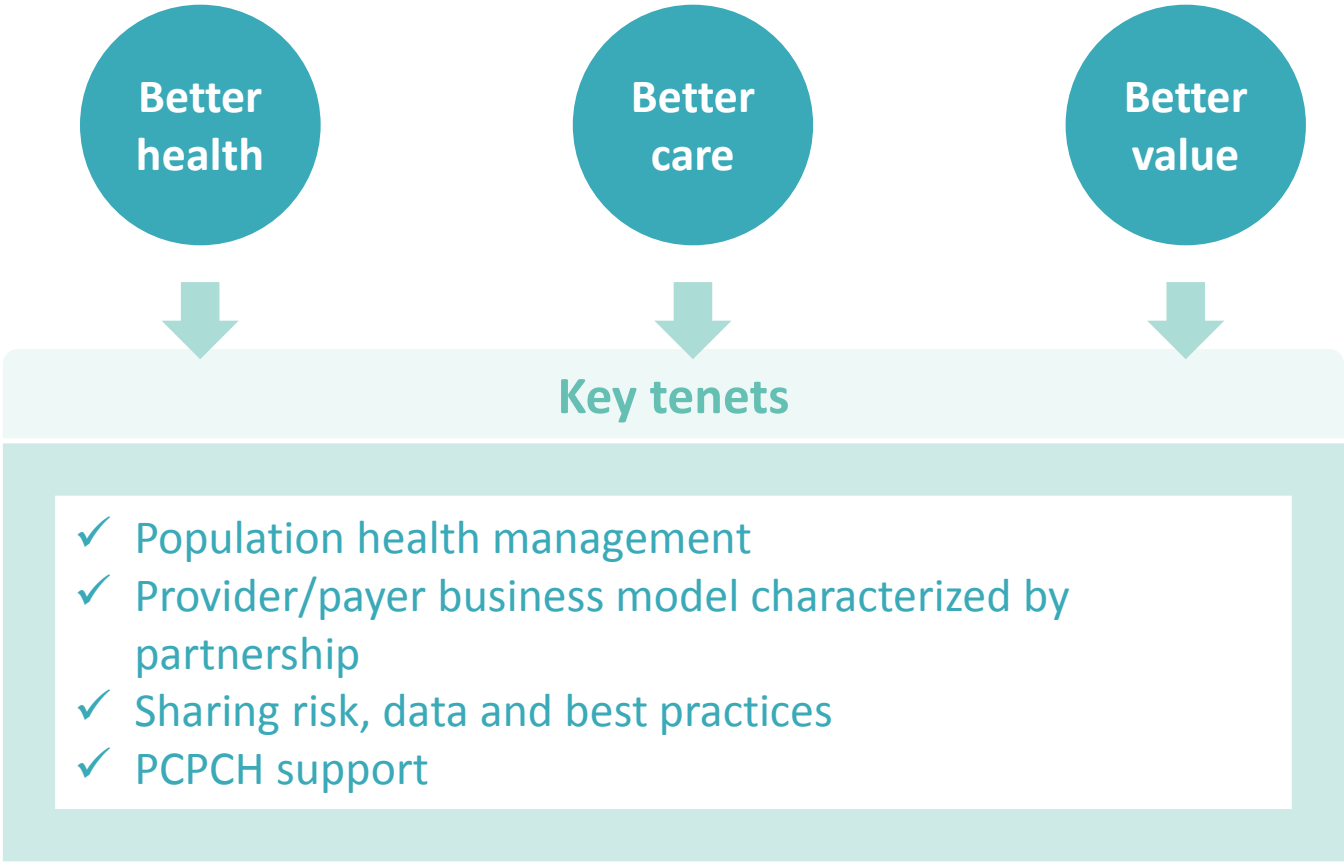
- CCN
  - Tier 2 benefit plan for OHSU employees only with participation in select counties determined by OHSU (closed panel):
    - Clackamas, Deschutes, Marion, Multnomah, Polk, Washington and Yamhill counties

Value-based care networks

Value-based care networks

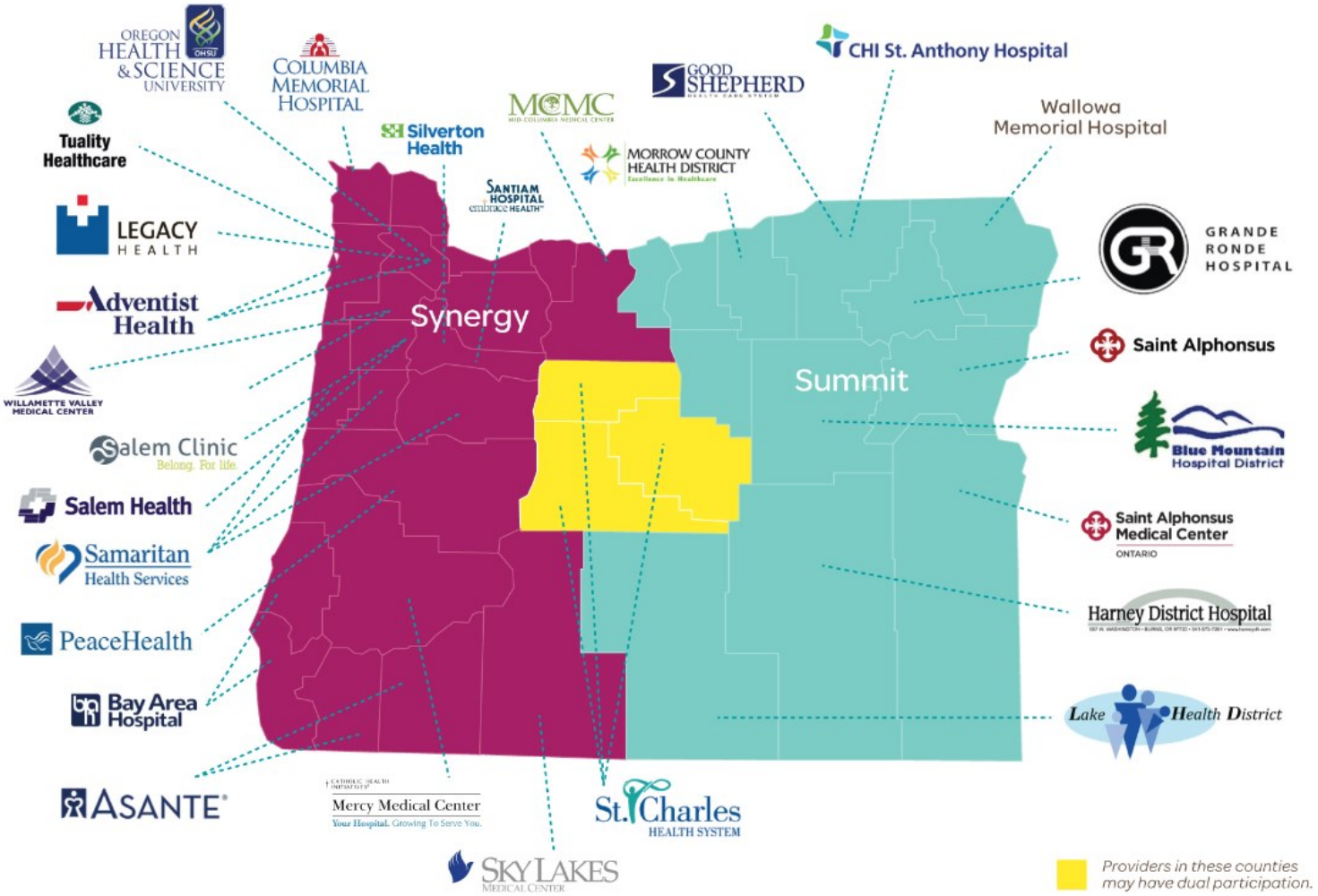
Overview

- **Synergy, Summit, Beacon, Affinity and Cornerstone**



Value-based care networks

Synergy and Summit



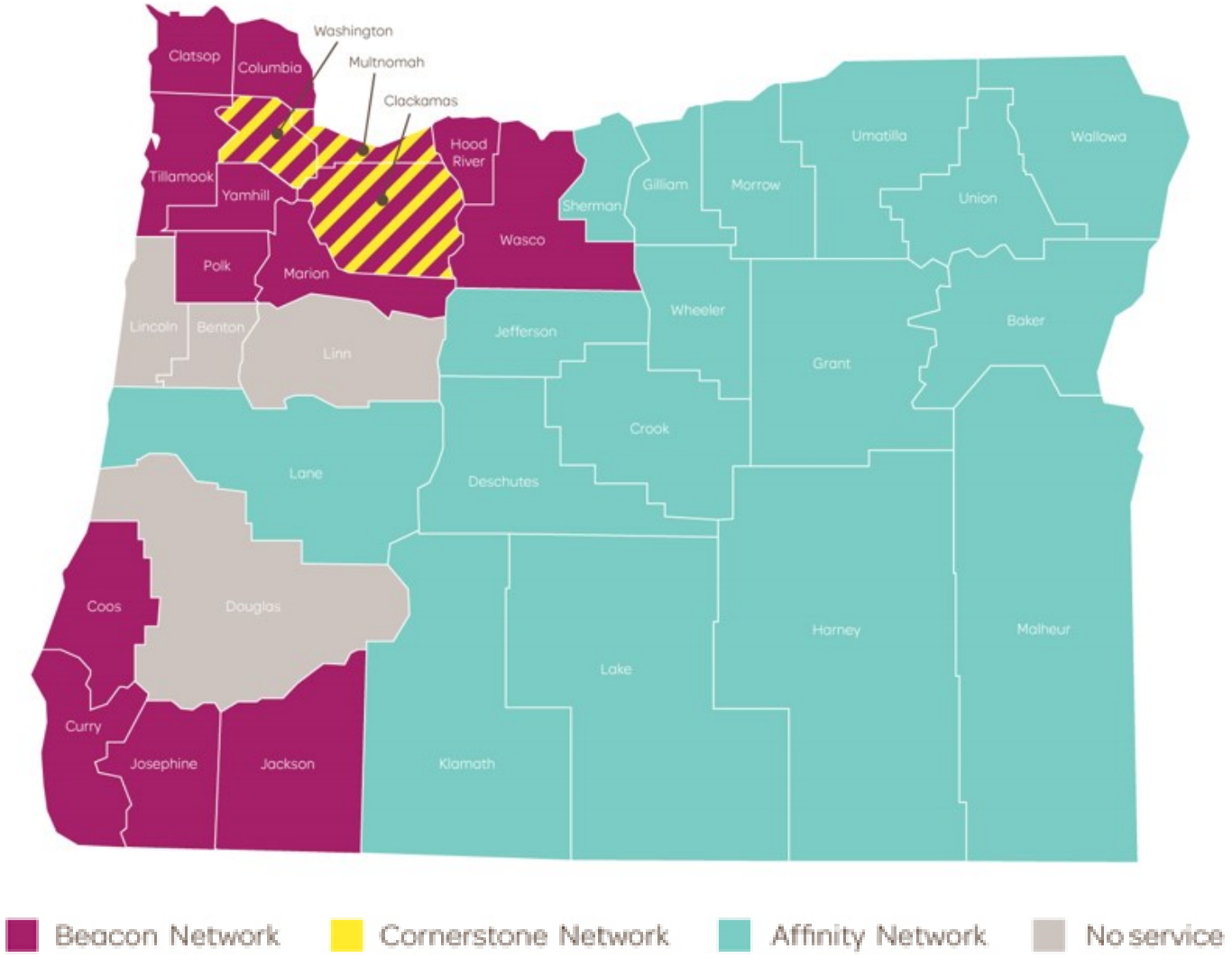
Value-based care networks

Synergy and Summit

- What are the Synergy and Summit networks?
    - Clinically integrated networks with participating health system partners and their referring providers
    - Available to small and large employer groups
    - PCP selection is required

Value-based care networks

Individual networks



Value-based care networks

Beacon

- What is the Beacon network?
  - Clinically integrated network, which includes nine health system partners and their referring providers
  - PCP selection is required
- What's new for 2019?
  - Network refinement in the Portland metro area

Value-based care networks

Affinity

- What is the Affinity Network?
  - Clinically integrated network, which includes 12 health system partners and their referring providers
  - PCP selection is required
  - No network changes for 2019

Value-based care networks

Cornerstone Network

- What is the Cornerstone Network?
  - Effective Jan. 1, 2019
  - Legacy Health based network
  - Available to individuals residing in Clackamas, Multnomah and Washington counties
  - PCP selection is required

Commercial benefits

2019 Benefit changes

Commercial benefits

OEBB

- All current medical plans will continue to be offered (Alder, Birch, Cedar, Dogwood, Evergreen)
  - New Fir high-deductible plan
- No changes to deductibles, out-of-pocket limits, copayments or coinsurance
- Nutritional therapy is covered for all eating disorders when medically necessary
- Cholera vaccine is covered for members, age 18-64 traveling in areas with endemic or epidemic cholera

Commercial benefits

PEBB

- Both Synergy and Summit plans will continue to be offered
- Virtual Visits offered through OHSU (www.ohsu.edu/virtualvisits)
  - PEBB members receive the Virtual Visit benefit at no cost share
- ER copay increased to $150
- Nutritional therapy is covered for all eating disorders when medically necessary
- Cholera vaccine is covered for members age 18-64 traveling in areas with endemic or epidemic cholera

Commercial benefits

OHSU

- OHSU PPO
  - Tier I: OHSU PPO Network
  - Tier II: CCN with PHCS for those that are out of area
  - Tier III: OON
- HDHP with HSA (new)
  - Tier I: OHSU PPO Network
  - Tier II: CCN with PHCS for those that are out of area
  - Tier III: OON
- Regional Medical Home
  - Tier I: Synergy or Summit
  - Tier II: OON
- Pharmacy benefits will be administered by OHSU

Commercial benefits

Salem Health

- Emergency Department copay - $250
- Newborns must be actively enrolled with the employer group within 30 days
- All other benefits will remain the same

Commercial benefits

TruHearing

Benefit	Commercial
In-network benefit - member Out-of-pocket Cost (copayment)	Max $1500 based on defined formulary
Product details	Options from all TruHearing manufacturer partners available
Hearing	Defined formulary of hearing aids from the top hearing aid manufacturers: Signia, Oticon, Widex, Phonak, ReSound, Starkey
Hearing exam Includes three free hearing aid fittings	Varies by plan - some may be subject to deductible, coinsurance, etc

Commercial benefits
Individual/exchange plans

- All individual/exchange plans offered in 2019 will be Exclusive Provider Organization (EPO)
  - EPO plans do not have out-of-network benefits
- Individual/exchange members must select a primary care physician (PCP)
- Members who do not select a PCP will automatically be assigned one based on where the member resides

Commercial benefits

Primary care assignment

- VBC plans require selection of a Medical Home or PCP assignment for each covered individual
  - Each family member makes their own selection
- Must use selected Medical Home or primary care physician for primary care services in order to receive in-network benefits
- Primary care received ***outside*** of your selected Medical Home or assigned PCP will be processed and paid as ***out-of-network***

Medicare Advantage updates

Medicare Advantage updates

2019 plan changes

- Six regional MA plans effective Jan. 1, 2019
- Medicare Advantage PPO
  - PPO
  - PPORX
  - PPORX Enhanced **(new)**
- Medicare Advantage HMO
  - HMO
  - HMO Basic **(new)**
  - HMO Enhanced + RX **(new)**

Medicare Advantage updates
HMO care coordination

- PCP selection required
- All non-primary care services require a plan notification referral from PCP except under the following circumstances:
  - 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 Advantage updates
2019 benefit changes

- Medicare Advantage benefit updates:
  - Telehealth — expanding the Medicare telehealth benefit to allow telehealth services for members in any rural, suburban or urban location
    - Web-based services and 24-hour nurse line
  - Embedded dental benefit
  - Routine vision exam and hardware (VSP)
  - Routine physical (in addition to annual wellness exam)
  - Routine hearing exams and hearing aids (TruHearing)

Medicare Advantage updates

TruHearing

Benefit	Advanced Model	Premium Model
In-network benefit — member Out-of-pocket Cost (copayment)	$699	$999
Product details	› 32 channels/six programs › Direct smartphone connectivity › Full range of styles and colors	› 48 channels/six programs › Direct smartphone connectivity › Integrated lithium ion rechargability › Full range of styles and colors
Hearing exam Includes three free hearing aid fittings	$45.00 copay	
➢ One of the largest hearing aid dispensers in the U.S. ➢ Offered benefit will save members money		
➢ Mandatory Supplemental Benefit ➢ Hearing aids and fitting exam ➢ Does not apply to maximum out-of-pocket (MOOP) ➢ Access to a national network		
Member Experience	Contact information	Services include
Member will contact TruHearing direct for services	866-929-6749 (direct to TruHearing) 866-929-7564 (Moda Health Customer Service)	Advanced and premium hearing aid selections

Medicare Advantage updates

Vision Service Plan — VSP

- Covers routine vision exam with a $0 copay and hardware at no cost
- Mandatory supplemental benefit
- Does not apply to maximum out-of-pocket
- Routine vision hardware is every two calendar years
- Routine vision is every calendar year

Medicare Advantage updates

Vision Service Plan — VSP

Plan Highlights	In-Network Benefit (Member Pays)	
Routine Vision & Hardware	Vision Exam $0.00 Eye Wear $0.00	
➢ Mandatory Supplemental Benefit ➢ Does not apply to maximum out- of -pocket (MOOP) ➢ Routine vision hardware is every two calendar year ➢ Routine vision is every calendar year	➢ Members will have access to care from eye doctors from a National Network ➢ Every VSP network doctor features a wide selection of designer frames	
Member Experience	Contact Information	Services include
Member will contact VSP direct for services	844-693-8863 (Provider Assistance #1) 844-693-8863 (Moda CS)	Vision exams and Eye Wear

Medicare Advantage updates

Extra Care

- Available at an additional premium per month and includes non-Medicare covered services such as:
  - Chiropractic
  - Naturopathic
  - Acupuncture
- 50 percent coinsurance for services up to a $500 maximum benefit per year
- Extra Care enrollment can be verified in EBT

Patient name:

GENDER	RELATIONSHIP	BIRTH DATE	PLAN BEGIN	PLAN END	STATUS	COB BEGIN	COB END
Male	Subscriber		01/01/2017	--/--/----	Active		

Notes

Extra Care Benefit: 50% to a combined maximum benefit of $500 per calendar year for all care (in and out-of-network) for glasses, contacts, hearing aids, hearing test, acupuncture, naturopathic care, and chiropractic services that are not covered under the basic Moda Advantage plan. Extra care benefits do not require prior authorization.

Manual manipulation of the spine to correct subluxation is covered under the basic plan according to Medicare Guidelines. Chiropractic services no longer require prior authorization effective 7/1/16.

Medicare Advantage updates
Silver&Fit® exercise and healthy aging program

- The Silver&Fit benefit is now available on all Medicare Advantage 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
- *The Silver Slate®* quarterly newsletter
- $0 copayment

Medicare Advantage updates
Preventive and comprehensive dental

- Mandatory supplemental benefit
- Preventive and comprehensive dental services are combined to a maximum $500 per calendar year
- Does not apply to maximum out-of-pocket (MOOP)
- Use any Medicare-eligible provider

Medicare Advantage updates

2019 Part D — PPORX

• Deductible	$120
• Tier 1 (preferred generic)	$2
• Tier 2 (non-preferred generic)	$20
• Tier 3 (preferred brand)	$45
• Tier 4 (non-preferred Brand)	$100
• Tier 5 (specialty tier)	30 percent coinsurance (1 month supply)

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

- 2019 coverage gap
  - Generic — member pays 44 percent of plans cost
  - Brands — member pays 35 percent of the negotiated cost
  - Closed formulary — PDF available on our website

Medicare Advantage updates

2019 Part D — 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 percent coinsurance (1 month supply)

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

- 2019 coverage gap
  - Generic — member pays 44 percent of plans cost
  - Brands — member pays 35 percent of the negotiated cost
  - Closed formulary — PDF available on our website

Medicare Advantage updates
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
  - Rheumatoid arthritis
- Take five or more medications
- Have drug costs that total $4,044 or more annually

Medicare Advantage updates
Covered vaccinations

- Seasonal flu
  - Quadrivalent (CPT 90682)
  - New code effective 1/1/2019 (CPT 90689)
  - Covered when provided by an in-network provider or pharmacy
- Shingles
  - Shingrix (CPT 90750)
  - Only covered when administered in a pharmacy
  - Member cost sharing may apply
- Pneumococcal
  - Prevnar (CPT 90670) and Pneumovax (CPT 90732)
  - Covered when administered by an in-network provider

Medicare Advantage updates

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

Medicare Advantage updates

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

- Attestations are completed at the individual practice level and not by organization

- For questions, please contact delegatecompliance@modahealth.com or providerattestation@modahealth.com

Medicare Advantage updates
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
- Participating Medicaid/EOCCO practices will need to submit additional information

Medicare Advantage updates
Organization determination

- ABN-like forms cannot be used with Medicare Advantage plans
- If provider or member are uncertain if a particular medical service will be covered by the plan, provider should submit an Organization determination request
  - Do not provide service in question until decision has been made
  - If deemed covered, provide service and bill Moda Health directly
  - If deemed not-covered, enter into financial arrangement with patient and collect from patient only
  - Bills sent to Moda in error for services not-covered will be denied to provider write-off

Medicare Advantage updates

Organization determination

Contracted providers will not balance bill member for:	Correct handling of Medicare Advantage per CMS
Services explicitly excluded by Medicare	Arrange a cash transaction with the Medicare Advantage beneficiary in advance of services provided
If uncertain that services will be covered	• Request an organizational predetermination • If the services are not covered, arrange a cash transaction with the Medicare Advantage beneficiary in advance of providing services
Referrals to out-of-network providers Referrals to an out-of-network provider includes authorization on behalf of Moda Health for coverage excluded or non-covered services	• Verify lab or other provider is contracted with Moda Health Medicare Advantage • Refer to an in-network lab or provider if possible • Document financial responsibility conversation with beneficiary, and that they wish to pay cash for any non-covered service

Be better