2022 Provider Workshop

Presented by Moda Health

2022 Provider Workshop

Welcome

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Primary care

Agenda — PCP

- Diversity, Equity and Inclusion surveys
- Commercial networks/benefit changes
- Value-based care
- PCP requirements
- Claims
- Prior authorizations/referrals
- Healthcare services
- Reconsiderations and appeals
- HEDIS
- Medicare Advantage
- Provider resources

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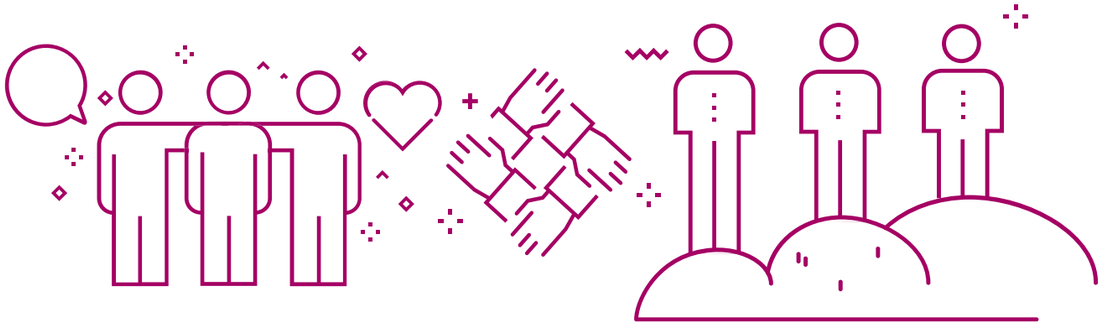
Diversity, Equity and Inclusion survey

- **Diversity:** We value, respect and celebrate people of all backgrounds, identities and abilities. And we actively seek to identify how uniqueness makes us better.
- **Equity:** We strive to understand the underlying causes of outcome disparities and actively work to increase justice and fairness in our processes, procedures and systems. We do this within our company and within our communities.
- **Inclusion:** We are committed to creating environments where every individual has an equal opportunity to belong and can be recognized for their inherent worth and dignity.



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Diversity, Equity and Inclusion survey

Currently, diversity among physicians is limited. Mounting evidence suggests when physicians and patients share the same race or ethnicity, it improves:

- Time spent together
- Shared decision-making
- Wait times for treatment
- Screening adherence
- Patient understanding of health risks
- Patient perceptions
- Treatment decisions

We invite you to share your demographic information with us.
Oregon medical and behavioral health providers:
modahealth.com/medical/forms.shtml

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Commercial networks

2023 Commercial networks

2023 Commercial networks — Group

Connexus	• Statewide PPO plan • PCP selection, referrals not required
Synergy	• Coordinated care plan for employer groups • Only Salem Health, OHSU and PEBB starting 1/1/2023
Moda Select	• Exclusive Provider Organization • Available in three counties (Multnomah, Washington and Clackamas) • PCP selection required

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2023 Commercial networks — Group

OHSU PPO	• OHSU employee plan • Tiered benefits • Provider participation determined by OHSU
OHSU EPO	• OHSU employee plan • Tiered benefits; no out-of-network coverage • Provider participation determined by OHSU
HMC & OHSU Health	• Hillsboro Medical Center employee plan • Provider participation determined by Tuality
CCN	Tier 2 benefit plan for OHSU PPO and OHSU EPO

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2023 Commercial networks — Individual

Beacon

- Individual Exclusive Provider Organization plan sold in/out of the Exchange
- Available in 13 counties

Affinity

- Individual Exclusive Provider Organization plan sold in/out of the Exchange
- Available in 19 counties

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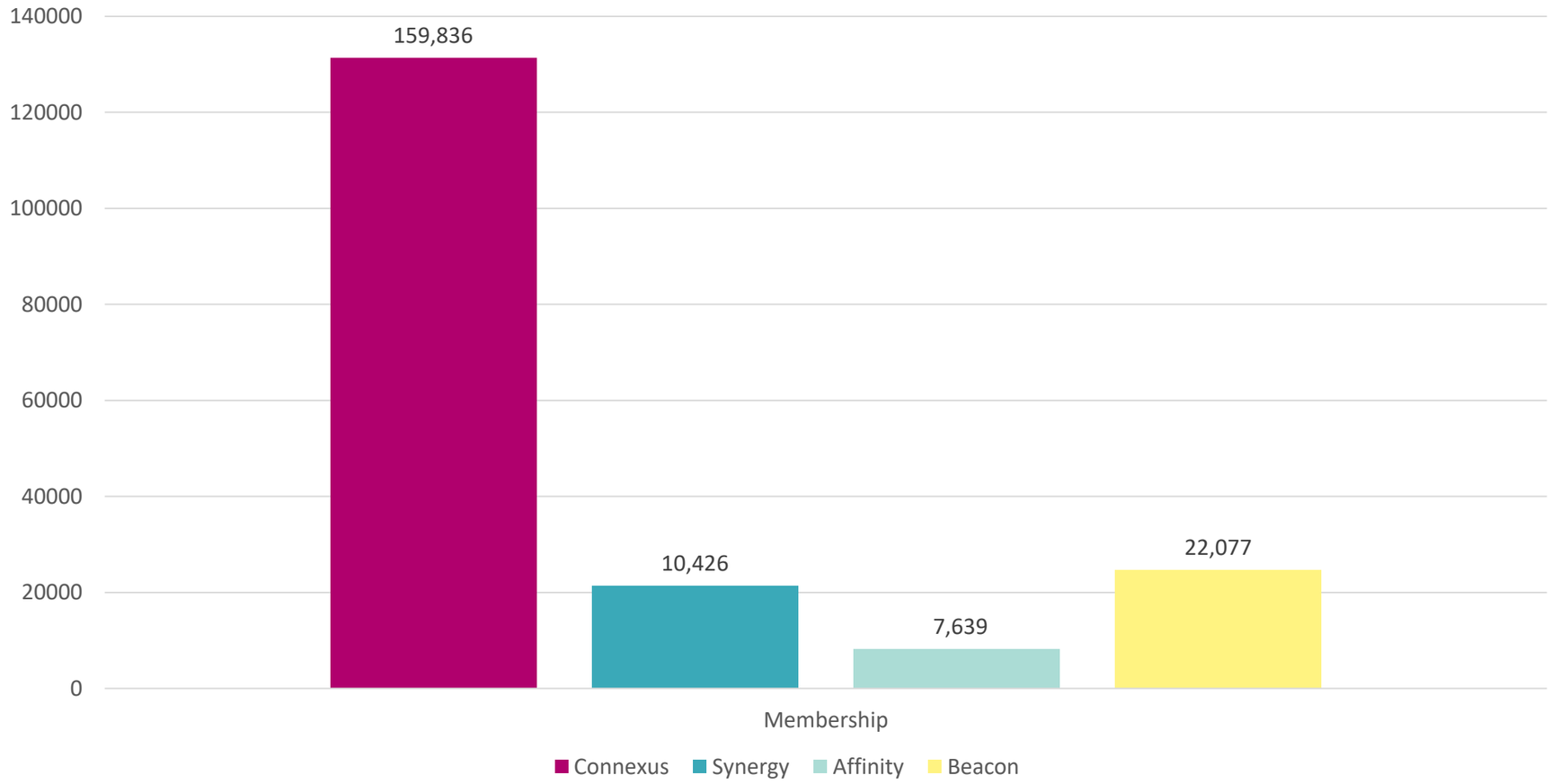
Commercial membership



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Commercial group networks

Connexus
Small and Large Group plans

- 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

Synergy Network

- Only Salem Health, OHSU and PEBB starting 1/1/2023
- No Referrals required
- Synergy members need to select a PCP to receive Tier 1 benefits
  - Each family member makes their own selection
- PEBB Synergy members must pick a “PCP 360” provider

Moda Select
Small and Large Group plans

- Moda Select
  - Exclusive Provider Organization (EPO)
  - PCP Selection is required
  - No referrals required
  - No out-of-network benefits
  - Group members residing in Clackamas, Multnomah and Washington counties
  - Texas and Idaho

OHSU and CCN networks

- OHSU PPO
  - Tier 1 benefit plan for OHSU employees only with statewide participation determined by OHSU (closed panel)
- OHSU EPO
  - Tier 1 benefit plan for OHSU employees in the Portland Metropolitan Area (closed panel)
- CCN
  - Tier 2 benefit plan for OHSU PPO and OHSU EPO only with participation determined by OHSU (closed panel)
- HMC – Hillsboro Medical Center & OHSU Health Employee Plan
  - HMC employee plan (closed panel) aka Tuality Health and Associates

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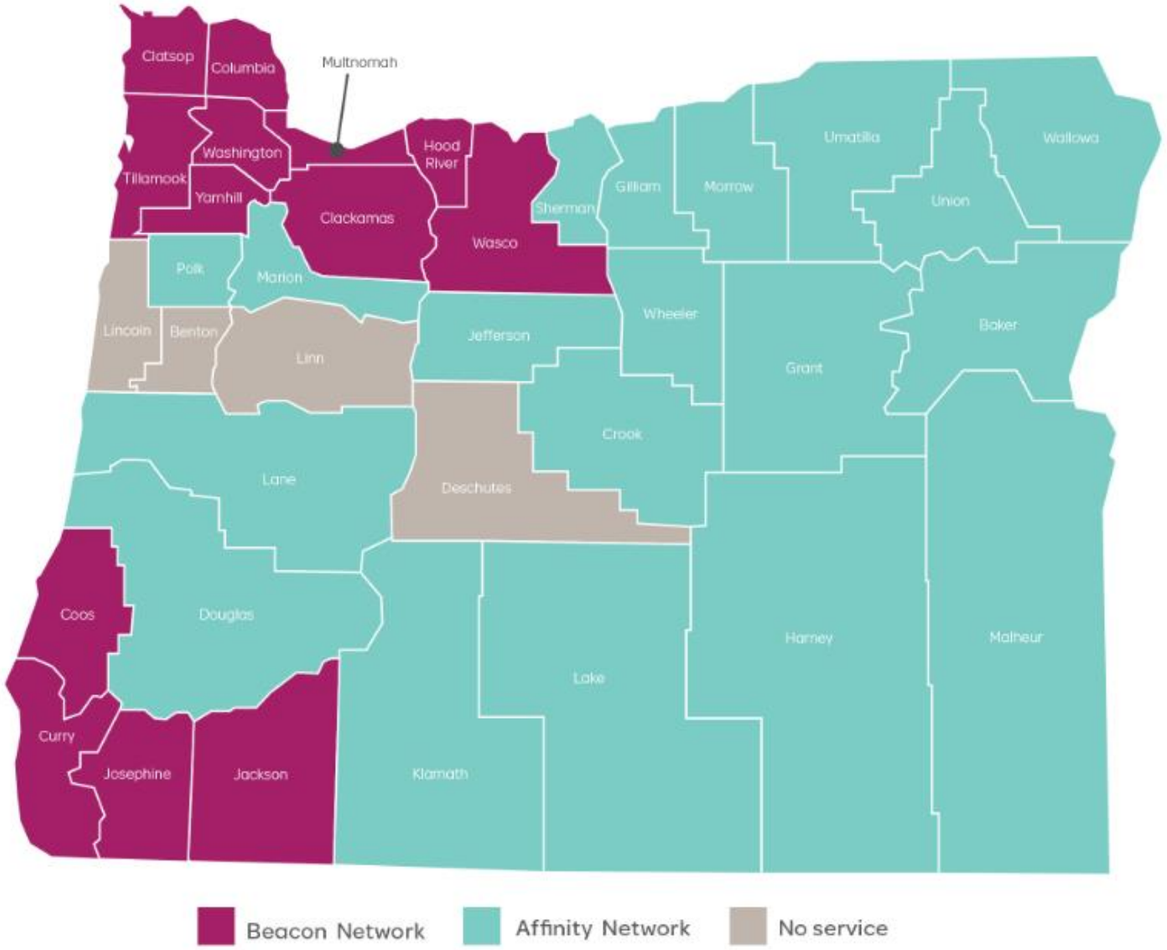
Individual networks

Individual network service area



Beacon Network

- What is the Beacon Network?
  - Clinically integrated network, which includes 10 health system partners and their referring providers
  - PCP selection is required
  - Exclusive Provider Organization (EPO)
  - No out-of-network benefits

Willamette Valley Medical Center
Columbia Memorial Hospital
Adventist Health
MCMC Mid-Columbia Medical Center
Oregon Health & Science University OHSU
Southern Coos Hospital & Health Center We're here for life!
Bay Area Hospital
TualityHealthcare The right care. Right here.
ASANTE
Curry Health Network

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Affinity Network

- What is the Affinity Network?
  - Clinically integrated network, which includes 15 health system partners and their referring providers
  - PCP selection is required
  - Exclusive Provider Organization (EPO)
  - No out-of-network benefits

Blue Mountain Hospital District
CHI St. Anthony Hospital
Good Shepherd Health Care System
Grande Ronde Hospital
Harney District Hospital
Lake Health District
Morrow County Health District – Excellence in Healthcare
PeaceHealth
Saint Alphonsus
ASANTE
Sky Lakes Medical Center
Salem Health Hospitals & Clinics
Wallowa Memorial Hospital
CHI Mercy Health – Mercy Medical Center
St. Charles Health System

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Commercial benefits

2023 Benefit changes

Commercial benefit changes

- OEBB
  - No changes for 2023
- PEBB
  - No changes for 2023
- OHSU
  - No changes for 2023
- Beacon/Affinity
  - No changes for 2023

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Value-based care programs

Value-based care
Primary care assignment

- Requires selection of a primary care provider (PCP) assignment
  - Each family member makes their own selection
- Must use selected PCP for primary care services in order to receive enhanced benefits
- Primary care received outside of your assigned PCP will be processed at a lower benefit level

Value-based care
PCP 360

- Coordinated care model (CCM) for OEBB and PEBB members, which focuses on primary care
- Encourages the use of high-performing PCPCH providers and coordinated care management
- Allows alignment with the Oregon Health System Transformation policies including:
  - PCPCH initiatives
  - Value-based payment models
  - Metrics alignment
  - 3.4% annual cost growth limit

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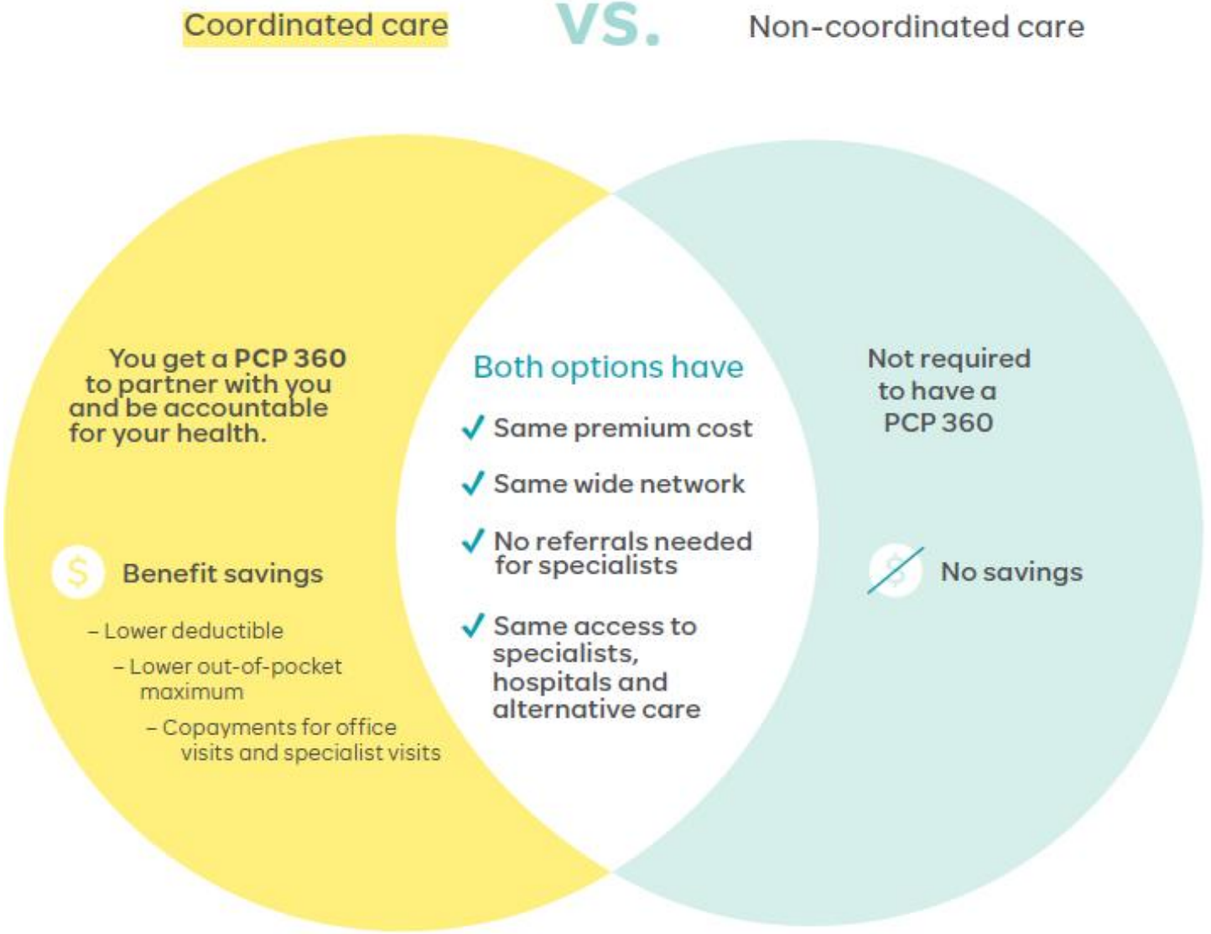
PCP 360 — OEBB


Coordinated care
VS.
Non-coordinated care
You get a PCP 360 to partner with you and be accountable for your health.
Benefit savings
– Lower deductible
– Lower out-of-pocket maximum
– Copayments for office visits and specialist visits
Both options have
✓ Same premium cost
✓ Same wide network
✓ No referrals needed for specialists
✓ Same access to specialists, hospitals and alternative care
Not required to have a PCP 360
No savings

Value-based care
PCP 360 provider requirements

- Patient Centered Primary Care Home (PCPCH) certified

or

- NCQA/PCMH certified
  (Bordering WA and ID counties)

and

- Signed OEBB/PEBB coordinated care model
  (PCP360/CCM) amendment

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Value-based care
PCP 360 provider directory identification

1 Distance: 2.0 mi
9300 SE 91st Ave Ste 200
Happy Valley, OR 97086
503-261-1171

2 Distance: 2.2 mi
16144 SE Happy Valley
Town Center Dr
HAPPY VALLEY, OR 97086
503-486-7040

3 Distance: 7.9 mi
25050 SE Stark Street Ste
300
Gresham, OR 97030
503-667-8878

4 Distance: 9.9 mi
1130 NW 22nd Ave Ste 320
Portland, OR 97210
503-295-2546

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Value-based care
PCP 360 payment model

- Care Management Fee (CMF)
  - Fund the implementation of the care delivery requirements for PCPCH and/or PMH certification
- Performance Based Incentive Payment (PBIP)
  - Retrospective payments to reward performance on utilization, quality and experience-of-care metrics
- Comprehensive Primary Care Payment (CPCP)
  - Prospectively paid PMPM with a corresponding Fee for Service (FFS) claims payment reduction
- Total Cost of Care Initiative (TCCI)
  - Retrospective payment for performing better than a total cost-of-care target

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Value-based care
Provider reporting

- Monthly roster
- Monthly clinical/utilization reports
- Monthly Quality Metrics reports
- Quarterly financial reports
- Questions? Providerreports@modahealth.com

Value-based provider reports
Data sharing/exchange

- Expanding data-sharing arrangements for CCM/PCP 360
- 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
- You can learn more about our Value-Based Data Sharing Program, data submission formatting guidelines and how to start sharing data by emailing: valuebaseddatasharing@modahealth.com

Moda 360

- How we identify members:
  - Social determinants of health data
  - Claims data
  - Care management inputs
  - Member questions and outreach
  - Clinical metrics

- Key partners work with PCP 360 directly when necessary
  - **Livongo:** Diabetes support
  - **Meru Health:** Behavioral health
  - **CirrusMD:** Telemedicine
  - **Strive Health:** Chronic Kidney Disease

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PCP requirements

PCP requirements

- Licensed:
  - M.D., D.O., N.P., P.A. or N.D.*
- Specialty:
  - Family practice
  - Internal medicine
  - Obstetrics/gynecology
  - Pediatrics
  - Geriatrics
- Provide services within their scope of practice as defined by law and state licensure
- Hospital admitting privileges or arrangements
- Authority to prescribe medication

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PCP requirements

- 24/7 PCP call coverage
- 3-year residency at an accredited program
- Participate in medical record audits
- Participate in office site visit
- Complete access and after-hours surveys
- Credentialed
- Contracted

PCP requirements

Moda Health access standards for medical services:

- Medical coverage is available 24 hours, seven days a week
- Emergency needs are immediately assessed, referred and/or treated
- Members requiring urgent, acute care are seen within 24 hours of request
- Established members with stable or chronic conditions are scheduled within 30 calendar days of the request

Call share

- PCP providers
  - Same Tax ID Number
  - Same network
  - PCP provider type

New patient vs. established

- When 99212-99215 (established patient) codes are reported for a new patient, a clinical edit denial will be generated
- Established patient with previous services occurring before the member became effective on the Moda Health plan
- Providers with a different specialty than another provider in the same group who has previously seen a patient, can bill a New Patient visit

modahealth.com/pdfs/reimburse/RPM076.pdf

Preventive care vs. medical

- Patient Protection and Affordable Care Act (PPACA)
  - Services covered at 100% when the member is seeing an in-network provider
- Moda Health covers a limited list of additional tests when billed with a routine, preventive or screening diagnosis code

modahealth.com/pdfs/reimburse/RPM037.pdf

Preventive care vs. medical

- Medical E/M visit combined with a preventive E/M visit
  - CPT guidelines define the documentation and coding requirements for reporting an additional problem-oriented E/M service in combination with the preventive E/M service code
- Lab tests ordered at an annual preventive health visit (99381–99397) are not automatically eligible for coverage under the no-cost-share Affordable Care Act preventive benefit
- Diagnosis codes must point to the correct procedure codes

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Claims

Contacting Moda Health
Moda Health Medical Provider Services

- Please start with our Medical Customer Service team for any claim issues or inquiries: medical@modahealth.com or 503-243-3962
- If Customer Service is unable to resolve your escalated claim inquiry, or if you have a contract interpretation question, please contact providerrelations@modahealth.com or your assigned representative
- Provide the following information via email:
  - Customer Service Tracking (CST) number
  - Claim and Member ID numbers
  - Any supporting documentation or correspondence

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Telehealth — temporary COVID-19

- Moda Health's website has the most up-to-date reimbursement policy for telehealth/telemedicine
  - Expanded telehealth policy valid during the Public Health Emergency (PHE) modahealth.com/pdfs/reimburse/RPM073_COVID-19TelehealthExpansion.pdf
  - Original telehealth policy modahealth.com/pdfs/reimburse/RPM052_TelehealthTelemedicine.pdf
- This policy is in effect until the agreement with the state of Oregon ends
- Medicare Advantage plans — until directed by CMS that the temporary expanded coverage has ended
- We will be given a 60-day notice for any changes to the PHE

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Claims
Corrected claims

- CMS-1500 (Professional)
  - Box 22 of the claim form should have resubmission code 7 (replacement) or code 8 (void/cancel)
  - Indicate “corrected claim” in box 19

- 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
Incident to services

- Commercial plans
  - Moda Health does not recognize or allow incident-to billing for Moda Health Commercial plans. Practitioners must bill under their own name and provider identification (NPI, TIN).

- Medicare Advantage plans
  - Moda Health follows CMS incident-to billing rules for our Medicare Advantage plans

modahealth.com/pdfs/reimburse/RPM040.pdf

Clinical edits

- Laterality diagnosis
- Age Inconsistencies diagnosis
- CMS Rate Sheets for Critical Access Hospitals (CAH) and Rural Health Clinics (RHC)
- NDC requirement for Nutrition

To view a complete list of Moda Health's reimbursement policies, please visit modahealth.com/medical/policies_reimburse.shtml.

Claims
Clinical edits — clinical editing systems

- Professional claims — professional clinical edits, Procedure to Procedure (PTP) edits and Medically Unlikely Edits (MUE) edits
  - Practitioner PTP edits apply to ASCs
- Facility claims — outpatient hospital CCI, PTP and MUE edits
- Claims exempt from Outpatient Prospective Payment System (OPPS) edits, status indicators and rules
  - Critical Access Hospitals (CAH) – Type of Bill 085x
  - Rural Health Clinic (RHC) – Type of Bill 071x
  - Federally Qualified Health Center (FQHC) – Type of Bill 077x

modahealth.com/pdfs/reimburse/RPM002.pdf

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Claims
Clinical edits — Medicare Advantage LCD/NCD edits

- CMS documents a wealth of very specific coding and coverage requirements
- National Coverage Determinations (NCDs)
- Local Coverage Determinations(LCDs), e.g., Noridian LCDs, transmittals, MLN articles and other sources
- Example: Why am I getting denials of CPT code 85025?
  - Claims for CPT code 85025 will deny for not meeting medical necessity criteria when not billed with approved diagnosis code from NCD 190.15 Blood Counts

modahealth.com/pdfs/LCD_NCD_edit_FAQ.pdf

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Claims
National Correct Coding Initiative (NCCI) links

- MUE information: cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE
- PTP coding edit information: cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits
- NCCI FAQ: cms.gov/medicare/national-correct-coding-initiative-edits/ncci-faqs

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Benefit Tracker

- Access BT from two platforms:
  - Moda Health — modahealth.com/medical/mbt.shtml
  - OneHealthPort — onehealthport.com/sso
- Access to detailed patient benefit information
- Search by Member ID#, SS#, first or last name and DOB
- Our website has additional information that OneHealthPort may not capture
- Login required for each site
- Information and questions, email — ebt@modahealth.com

Prior authorizations and referrals

Prior authorizations

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

- Failure to get prior authorization when required may result in claim denial. Members cannot be balance billed.
  - Note: Prior authorizations are not required when Moda Health is not the primary payer

Prior authorizations/referrals

- Commercial
  - Referrals are not required for members to see a participating specialist
  - Prior authorizations are required for non-par providers
  - Linn County is the only commercial plan with referral requirements

- Medicare Advantage
  - HMO plans require referrals from PCPs to specialists

- Providers are encouraged to refer to Moda Health participating providers in the member's assigned network(s)
  - Some plans have no out-of-network benefits
  - Refer to Find Care for participating providers

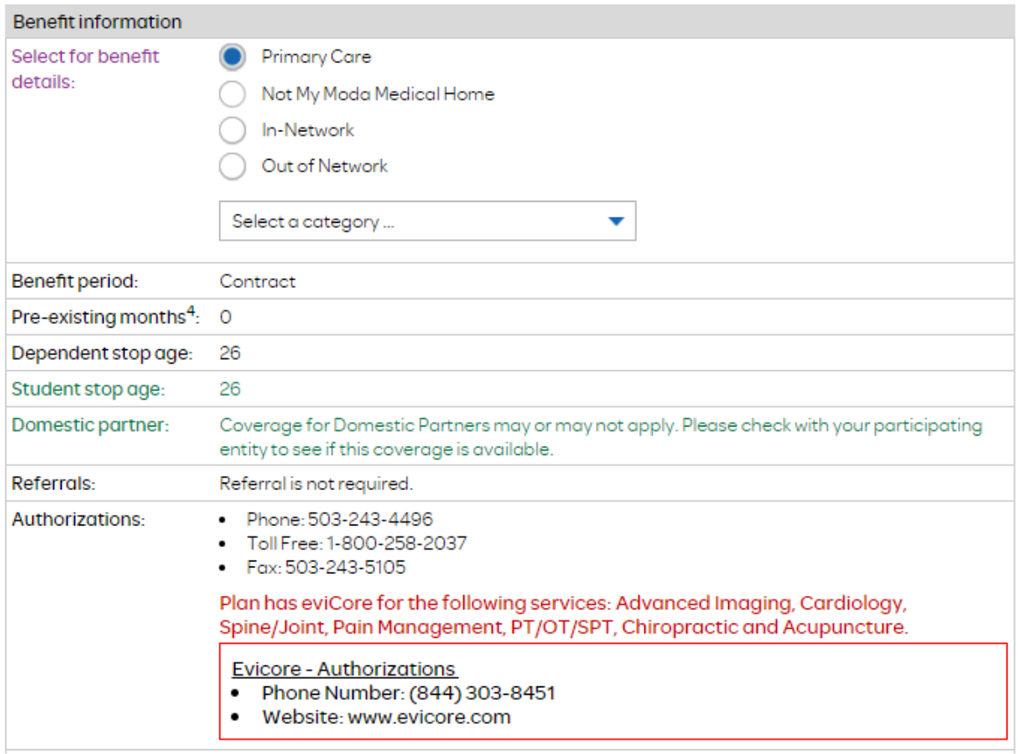
Prior authorizations
eviCore

- 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

Prior authorizations eviCore

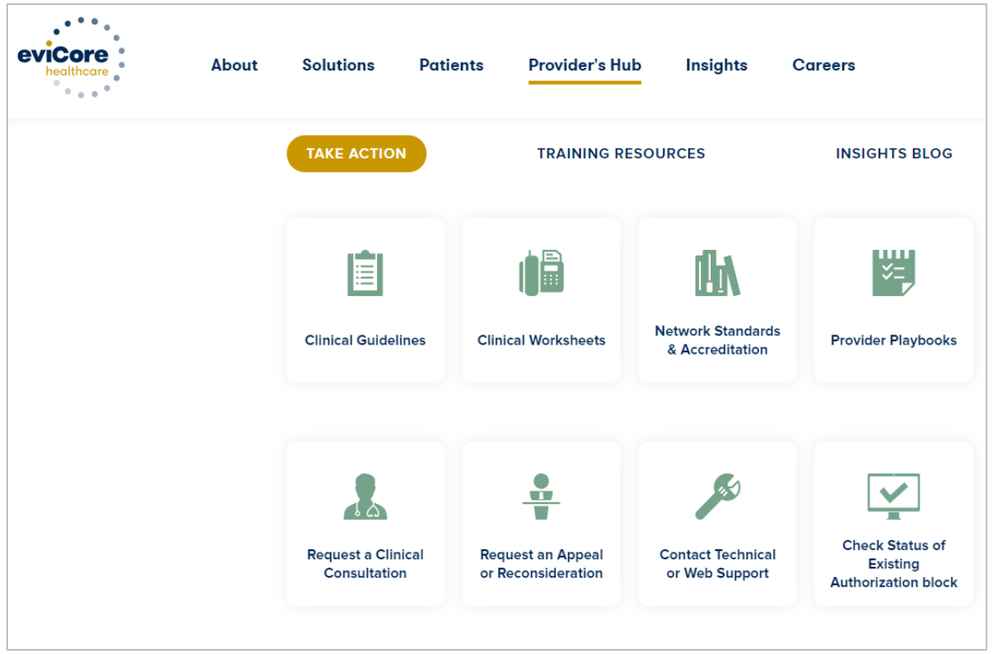
- Check Benefit Tracker to determine if the member's plan uses eviCore, and for what services
  - Can be found on main benefit page



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

Clinical guidelines
eviCore

- Provider's Hub
- Clinical guidelines/worksheets can be accessed before logging in to the portal
- Resources
  - Training resources
  - Video tutorials
  - How to's
  - evicore.com/provider
- eviCore also provides "WebEx Training" for new or experienced users twice per quarter for therapies PT, OT and ST
- eviCore Healthcare (webex.com)



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Clinical guidelines
eviCore

- Authorization denials
  - Peer-to-peer consultation
    - Can be requested through the provider portal
    - Request an Appeal (evicore.com)
  - Formal appeal
    - Process outlined on denial letter for members and providers
    - modahealth.com/pdfs/evicore_member_denial.pdf

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Prior authorizations
Magellan Rx

- Provider-administered injectable drug program
  - Prior authorization required for specific injectable specialty medications
  - modahealth.com/medical/injectables/
- Site of Care Program
  - Certain provider-administered drugs only authorized in outpatient setting or patient's home
  - modahealth.com/medical/siteofcare.shtml
- Claim edits program

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Prior authorizations
Magellan Rx

- Moda Health contracted providers have access to an online Magellan account
  - Visit the self-service provider portal at ih.MagellanRx.com
  - Select “New Access Request-Provider” under “Quick Links”
  - Select “Contact Us” to register

- Urgent or expedited request, call 800-424-8114

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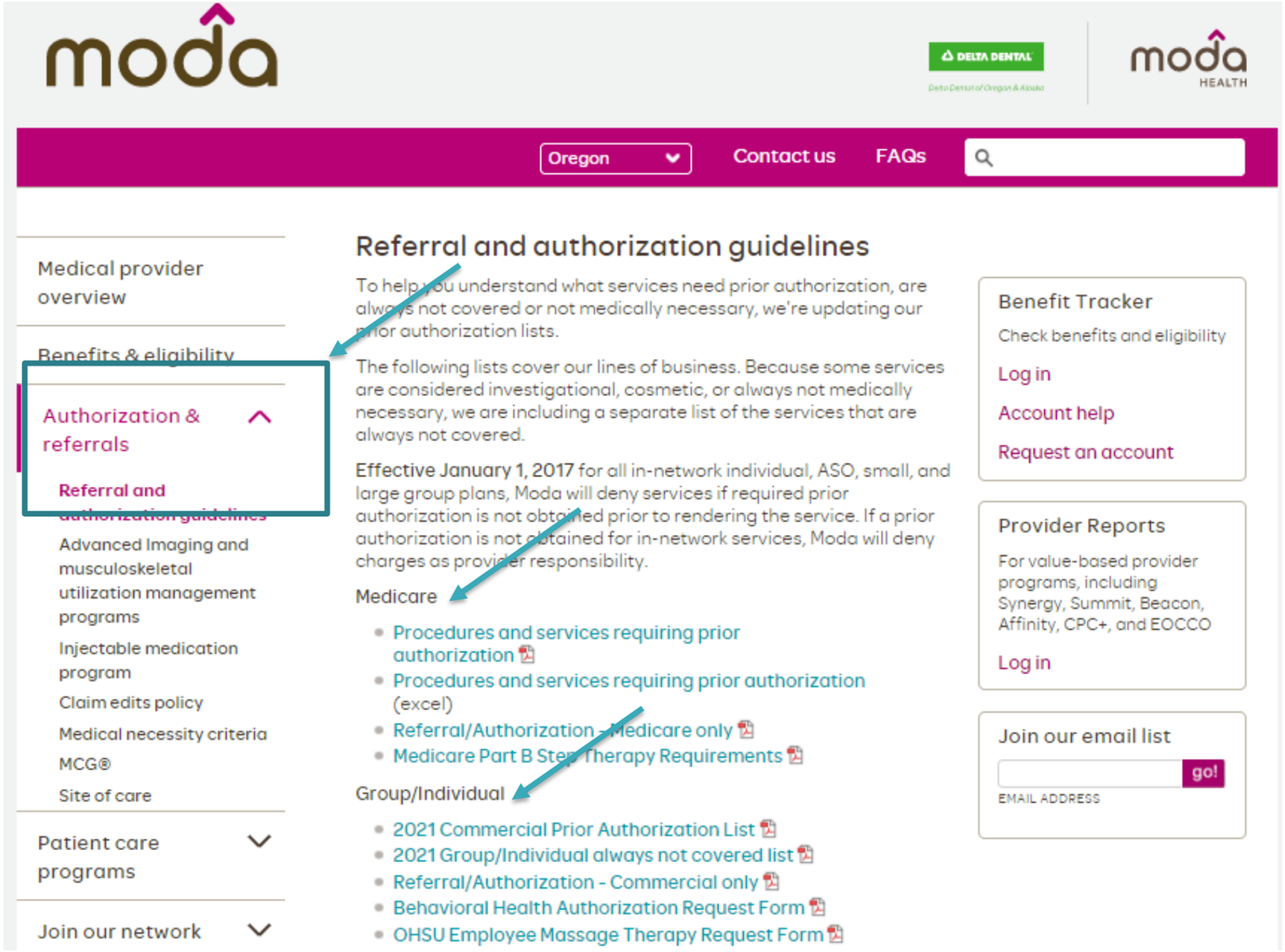
Prior authorizations
CoverMyMeds

- 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
- This does not replace Magellan Rx for injectable medications or Ardon Health for specialty pharmacy
- covermymeds.com



modahealth.com/medical/referrals/

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Healthcare Services

Emerging Health

- Emerging Health is a new, locally owned and operated home infusion and ambulatory infusion center located in Southwest Portland
- Committed to providing patients with exceptional experiences and healthcare solutions through infusion therapies
- Effective Sept. 1, 2022, Moda will utilize Emerging Health as our preferred Infusion provider
- To learn more, place a referral or arrange for a tour
  - Phone: 971-290-2010
  - Email: referrals@emerginghealth.com
  - Website: EmergingHealth.com

Site of Care Policy

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Case management

- Offered to Moda Health members needing assistance with complex health conditions or catastrophic events

- Make a referral by:
  - Phone: 800-592-8283
  - Fax: 855-232-6904
  - Email: casemgmtrefer@modahealth.com
  - Please include:
    - Member name and ID
    - Contact name and number
    - Reason for referral

Health navigators

- Member health navigators
  - Provide health education related to preventive health
  - Assist with provider searches, locating community resources, vendor programs, referrals to case management and health navigation
  - Provide in-depth disease management/self-management programs for members dealing with chronic health conditions and diagnoses

- Make a referral by:
  - Phone: 855-466-7155
  - Email: memberadvocateteam@modahealth.com or healthcoachteam@modahealth.com
  - Please include:
    - Member name and ID number
    - Contact name and number
    - Reason for referral

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Collective Medical

Who is Collective Medical?

Collective is a patient identification and tracking solution that gets the right information to the right person at the point of care. Our mission is to eliminate friction from care delivery through real-time collaborative care

A NETWORK

Collective is a network of hospitals, emergency departments, primary care, specialists, behavioral health, post-acute care, and health plans across the United States, sharing important patient information at the time of care

A PLATFORM

Collective is a platform that intelligently connects each member of a patient's care team for seamless collaboration at the right time and through the best medium

A COMMUNITY

Collective is a community of providers in the care of patients—especially those with complex medical needs—in your communities and across the country.

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Collective Medical

Getting Started

1. Connect with Moda Health to request a demo. michaela.nichols@modahealth.com
2. Request a Discovery Form from Moda – This is used to learn more about your organization. From there Moda will submit this to Collective and the three of you will work together to ensure a smooth onboarding process.
3. Complete the online agreements/contracts

How is cost covered?

By having Moda sponsor you! Providers without risk baring arrangements are eligible for standard clinic implementation at no cost.

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HEDIS

HEDIS

- HEDIS = Health Effectiveness Data Information Set
  - Standardized set of metrics created by NCQA that evaluates clinical quality
  - NCQA accreditation is considered an important indicator of a plan's ability to improve health

- Cotiviti
  - Fax requests
  - Onsite retrievals

- KDJ Consultants, Inc.
  - Remote EHR retrievals

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HEDIS: Remote EHR retrievals

- Our long-standing partners, KDJ Consultants, will work with you to establish remote EHR access
- During HEDIS season, KDJ Consultants will retrieve the required EHR information directly — freeing up your clinic's valuable resources and time
- Remote EHR access is safe, secure, HIPAA-compliant and HITRUST-certified
- For questions or to sign-up for our Remote EHR Access program, please contact HEDIS@modahealth.com

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HEDIS
Production timeline

January

Medical records requested

May

All medical records received

June

Submit results to NCQA

HEDIS
Medicare Stars measures

- Transitions of care
  - Ensure medication reconciliation is being conducted post-discharge. Ideally, this should be done with the member at follow-up.

- Follow-up after ED visit for people with multiple chronic conditions
  - Ensure patients with chronic conditions are being monitored and managed effectively and follow-up within seven days
    - COPD and asthma
    - Chronic kidney disease
    - Heart failure
    - Atrial fibrillation
    - Alzheimer’s disease and related disorders
    - Depression
    - Acute myocardial infarction
    - Stroke and transient ischemic attack

New Medicare Stars Measure changes 2023

Breast cancer screening

- Percentage of women MA enrollees 50 to 74 years of age who had a mammogram to screen for breast cancer in the past two years

- Measure is transitioning to exclusive use of the Electronic Clinical Data Systems reporting standard for Measurement Year 2023. This encourages the use and sharing of electronic clinical data among plans and health care providers.

Reconsiderations and appeals

Reconsiderations and appeals
Written or verbal request

- Providers may submit additional information in writing or verbally
- Within 30 days of pre-service denial
- Healthcare Services does not process a reconsideration request in the absence of new or additional information

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. The consultation:

- Is held within 10 days of the pre-service denial
- Is conducted with the medical director who did the initial denial
- May give new rationale for the requested service to support medical necessity

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 prior authorization 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
Expedited or rush requests

On receipt of a request, a Moda Health medical director decides whether the request qualifies for an expedited review

If the medical director qualifies the request, the staff processes it as expedited or rush

If it is decided that the request does not qualify for expedited review, the staff processes the request using the standard timelines

Reconsiderations and appeals
Provider appeals

- Please contact customer service first for denial inquiries
- If customer service cannot resolve, please follow the appeals process outlined in the provider manual
- Levels of appeal
  - Inquiry
  - First level appeal
  - Final appeal

Moda Health Plan, Inc.
Provider Appeal Unit
P.O. Box 40384
Portland, OR 97240
FAX 855-260-4527

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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
- modahealth.com/pdfs/auth_provider.pdf

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 Insurance Portability and Accountability 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

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2022 Provider Workshop

Medicare Advantage

Medicare Advantage partnership
Eastern Oregon

SUMMIT HEALTH

- Summit Health plans
  - Medicare Advantage plans went in effect in 2021 in Eastern Oregon counties
  - Available plans:
    - One HMO
    - Three HMO-POS
  - Summit Health will use the Moda Medicare Advantage network

- yoursummithealth.com

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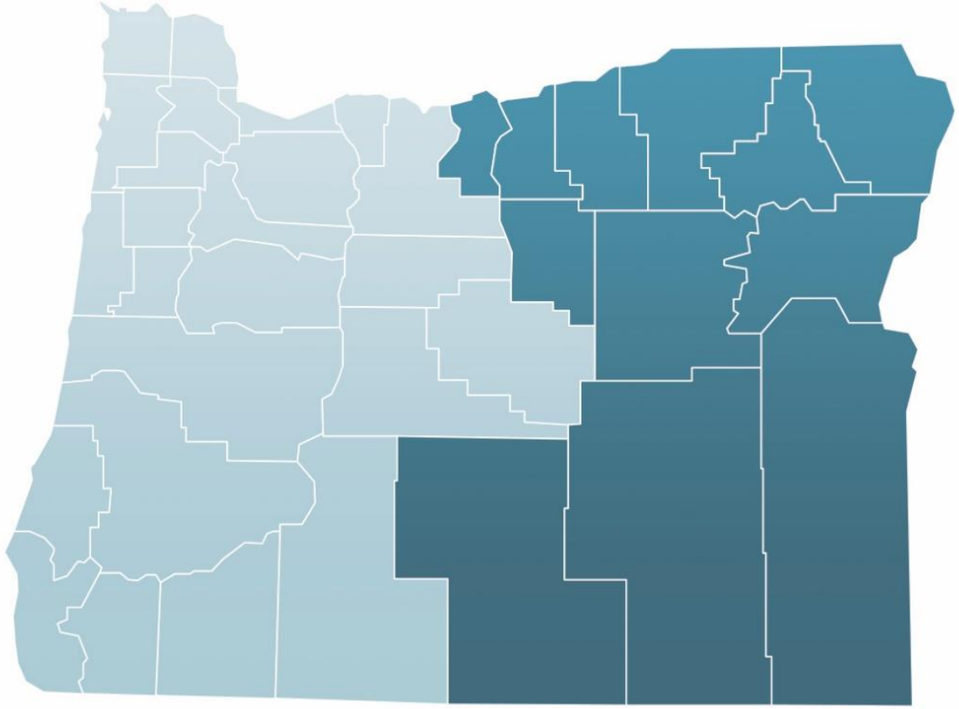
Summit Health partners



Saint Alphonsus
A Member of Trinity Health

CHI St. Anthony Hospital

Yakima Valley Farm Workers Clinic

GOOD SHEPHERD
HEALTH CARE SYSTEM

GRANDE RONDE HOSPITAL AND CLINICS

moda

GOBHI

Eastern Oregon IPA

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Contacting Summit Health

Customer service	844-827-2355 (toll-free) 541-663-2721 (local) 855-466-7208 (fax) MedicalMedicare@yoursummithealth.com
Provider Relations: Noah Pietz	503-265-4786 503-265-4790 (fax) providerrelations@yoursummithealth.com
yoursummithealth.com	

Medicare Advantage
2023 Benefit changes

- **PT, OT, ST**

-Does not require preauthorization

- **Out-of-network routine vision benefits available through VSP**

-Members will need to submit claims to VSP for 50% reimbursement

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Supplemental benefits – Notable change

Extra Care:

- No longer an optional supplemental benefit
- Embedded (aka mandatory) supplemental benefit on all Moda Health and Summit Health Medicare Advantage plans
- Same benefit structure, no extra premium
- Change noted in the Annual Notice of Change (ANOC)

Service	Cost-sharing
Routine chiropractic services	50% of the cost of the services
Non-Medicare-covered acupuncture	50% of the cost of the services
Alternative therapies (naturopathic services)	50% of the cost of the services
Combined annual maximum for all services	$500 annual benefit

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Medicare Advantage Supplemental benefits

- Dental: $500 embedded dental benefit will follow standard Coordination of Benefit (COB) rules with other dental coverage
- Vision: Routine vision services thru (VSP), including refraction
- Hearing aids: Hearing aids should be billed to TruHearing
- Silver&Fit® benefit*
- Livongo
  - Diabetes management
- CirrusMD
  - Telehealth services

*Not available with all Medicare Advantage plans

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Medicare Advantage
Medication Therapy Management Program

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

- Have two or more of the following chronic conditions:
  - Diabetes
  - High blood pressure
  - Asthma
  - Osteoarthritis
  - CHF (chronic heart failure)
  - ESRD
  - High cholesterol
  - Depression
  - COPD
  - HIV/AIDS
  - Rheumatoid arthritis
- Take five or more medications
- Have drug costs that total $4,935 or more annually

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Medicare Advantage Organization determinations

- CMS established rules about proper notice of non-coverage to Medicare Advantage members
  - Only a Part C or MA plan can issue a notice of non-coverage through an organization determination
  - Pre-service organization determination

- If a provider chooses to provide a service to a Medicare Advantage member without first ensuring the service is covered, the claim will deny to provider write-off and the member cannot be balance billed.
  - Example: refraction charges billed with medical vision services

Medicare Advantage 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 providers
  - Participating providers referring Medicare Advantage members to non-participating providers or agencies must get prior authorization for certain procedures and services as outlined in the Moda Health Medicare Advantage agreement

Medicare Advantage Compliance attestation

- Attestation will be online

- Information attesting to:
  - Reporting mechanisms and disciplinary standards
  - Sub-delegation contracts
  - Off-shore activities
  - OIG and GSA screening
  - modahealth.com/medical/med_compliance.shtml

For questions, please email:
delegatecompliance@modahealth.com or providerattestation@modahealth.com

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Medicare Advantage
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

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Provider resources

Contacting Moda Health Medicare Advantage

- Medical Customer Service
  - For questions about current member's medical claims
  - Phone: 877-299-9062
  - Email: medicalmedicare@modahealth.com

- Pharmacy Customer Service
  - For questions about current member's pharmacy claims
  - Phone: 888-786-7509
  - Email: pharmacymedicare@modahealth.com

- Hearing Aid Services/TruHearing
  - Phone: 866-929-6749 (TruHearing),
    866-929-7564 (Moda Health Customer Service)

- Vision services/VSP
  - Phone: 800-877-7195 (VSP),
    844-693-8863 (Moda Health Customer Service)

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- Medical provider overview
- Benefits & eligibility
- Authorization & referrals
- Patient care programs
- Join our network
- Provider resources
  - Claims and appeals
  - Policies and manuals
  - Clinical guidelines and tools
  - Contact us
  - Behavioral health
  - Preventive services
  - Medicare compliance
  - Forms
  - Samples
  - Workshops
  - Provider news
  - OEBB Reference Price Program
- Patient resources
- Pharmacy
- Quality of care

Find Care

Welcome, medical providers

Thank you for partnering with Moda Health. We appreciate your partnership because we know you – like us – are committed to providing our members with the best care.

As our valued partner, we want to make sure you have the tools and resources you need to continue providing excellent care.

Benefit Tracker

Moda Health's Benefit Tracker is an online resource designed with you in mind. With Benefit Tracker, you have the ability to look up all the information you need, such as:

- Benefits
- Eligibility
- Claims status
- Referrals

Log in to Benefit Tracker

- **Announcements**
- **Medical policy updates**
- **Prior authorization changes**

modahealth.com/medical/

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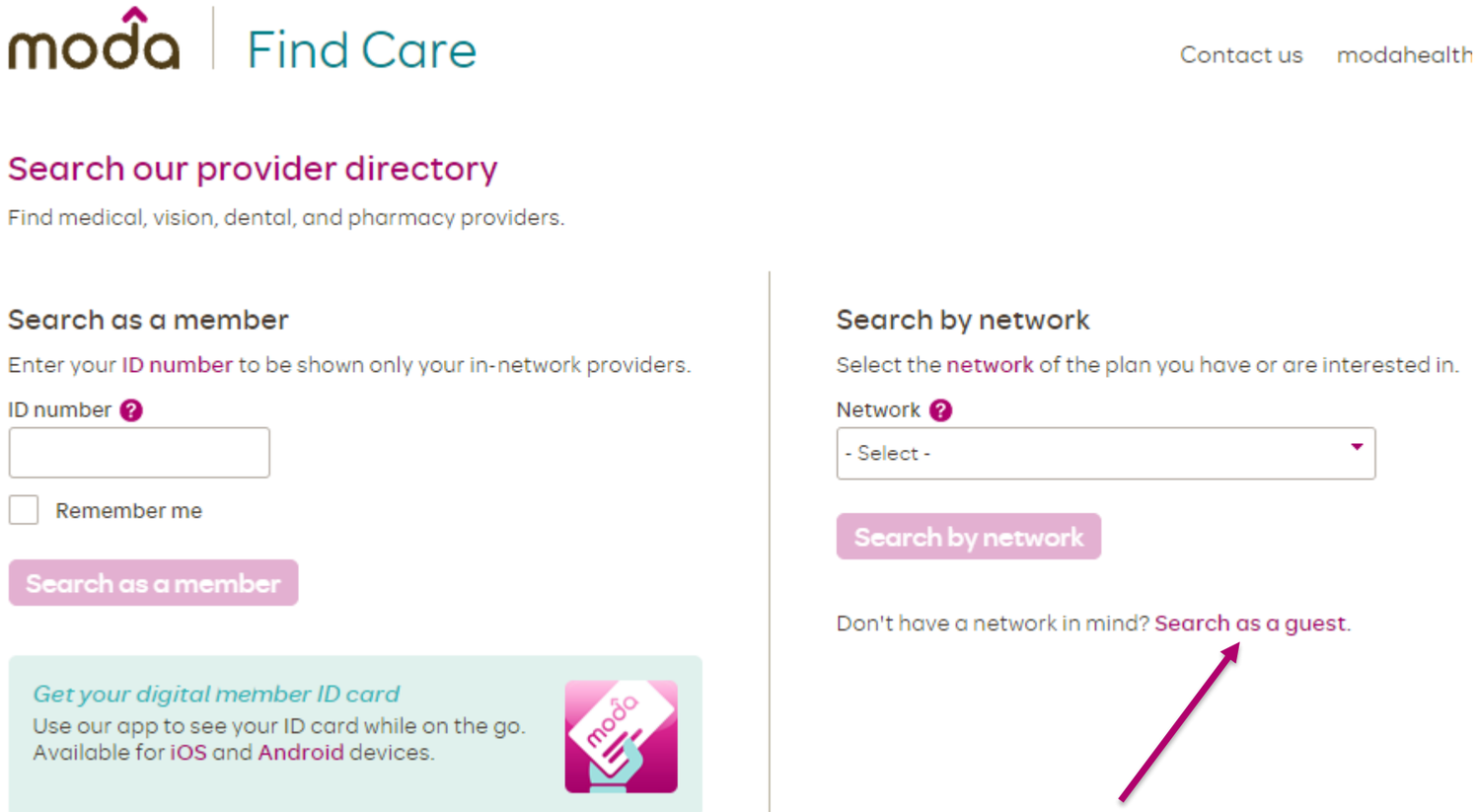
Provider resources
Find Care

[Moda Find Care | In-network doctors, dentists, and other providers (modahealth.com)]



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Contacting Moda Health

- Electronic Data Interchange (EDI) — For questions about electronic claim submission, payments and EFT/ERA enrollment form
  - Email: edigroup@modahealth.com
  - Phone toll-free: 800-852-5195

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

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

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Contacting Moda Health

- Medical Customer Service
  For questions about single claim inquiry, adjustment request, billing policies and our provider search tool (Find Care)
  - Email: medical@modahealth.com
  - Phone: 503-243-3962
  - Phone toll-free: 877-605-3229

- Moda Medical Provider Relations team
  - Please send your questions to providerrelations@modahealth.com

Thank you

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DELTA DENTAL®

Delta Dental of Oregon & Alaska