# MDwise Marketplace

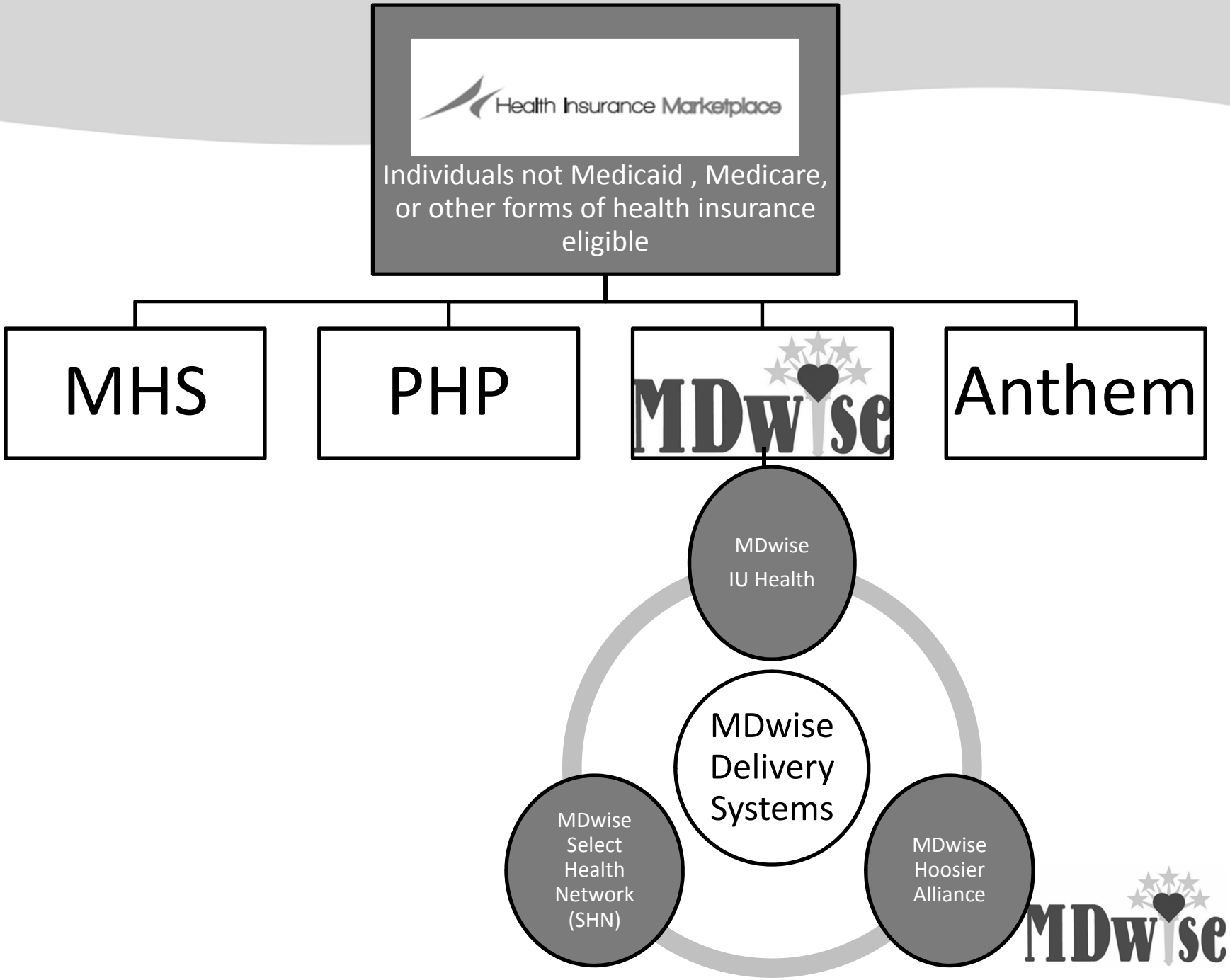
June 2014

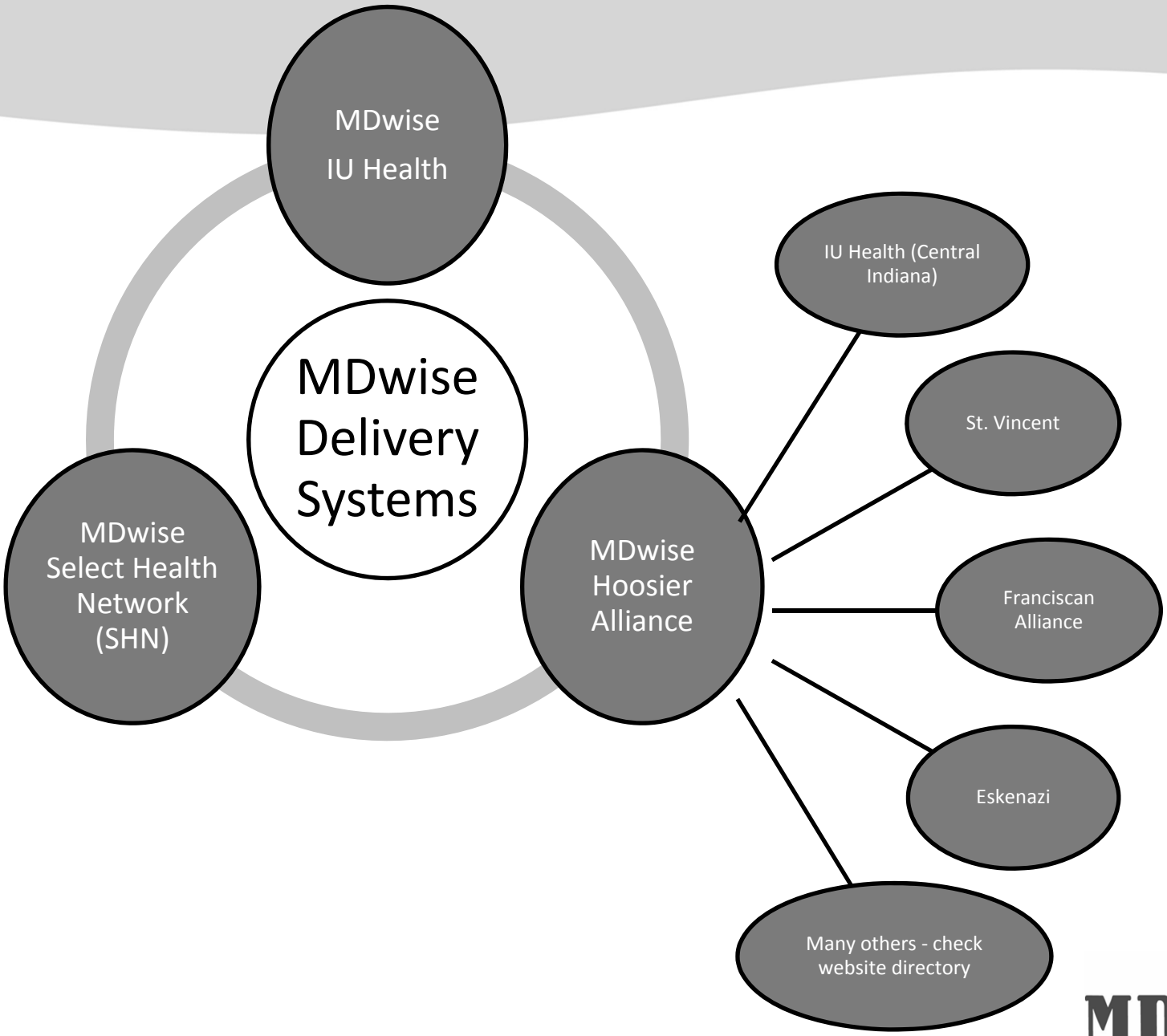
Exclusively serving Indiana families since 1994.

# Outline

1. Product Overview
2. Tiered Network
3. Filing Limit
4. PMP Rules
5. Provider Enrollment Strategy

MDwise has entered into an agreement with CMS to provide health insurance coverage through Qualified Health Plans on the Federally Facilitated Exchange.

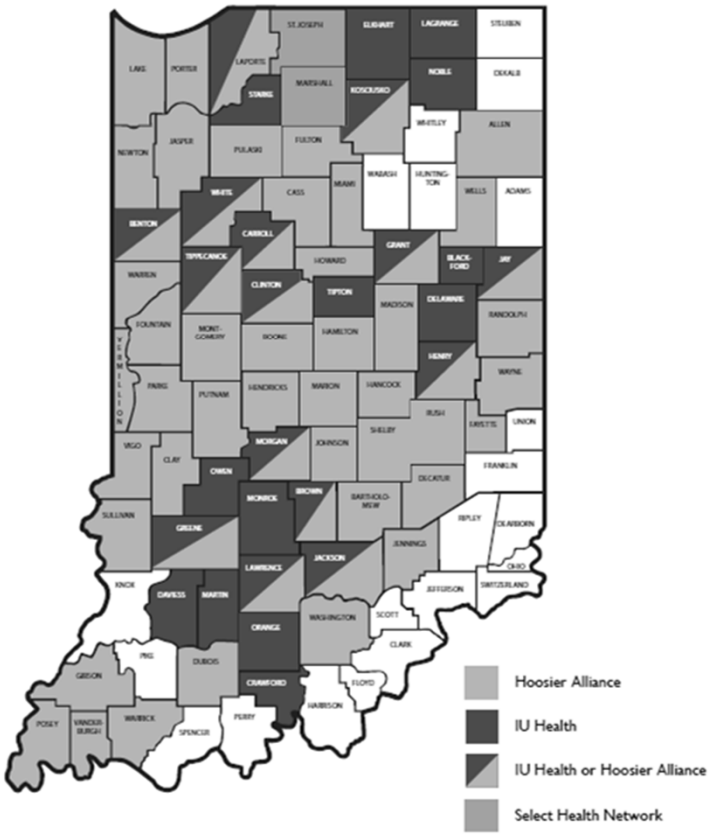

Health Insurance Marketplace
Individuals not Medicaid , Medicare, or other forms of health insurance eligible
MHS
PHP
MDwise
Anthem
MDwise
IU Health
MDwise
Delivery
Systems
MDwise
Select
Health
Network
(SHN)
MDwise
Hoosier
Alliance
MDwise


MDwise
IU Health
MDwise
Delivery
Systems
MDwise
Select Health
Network
(SHN)
MDwise
Hoosier
Alliance
IU Health (Central
Indiana)
St. Vincent
Franciscan
Alliance
Eskenazi
Many others - check
website directory

# Delivery System Map

## MDwise Marketplace Delivery System Coverage

MDwise offers the Marketplace product in the shaded counties on the map. Product availability is based on a member's residence. IU Health providers are included in the Hoosier Alliance delivery system for Hamilton, Hendricks and Marion counties.

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## Member Enrollment and Eligibility

The Health Insurance Marketplace is a new website to be offered by CMS,

- Designed like a "Expedia" to help individuals compare and purchase insurance.
- Consumers apply for a health plan on the Marketplace at www.healthcare.gov, or they can sign up using the toll-free hotline or the paper application that CMS will provide.
- Open enrollment occurs annually.
  - The next open enrollment will be during November 15th to February 15th.

HealthCare.gov

Learn | Get Insurance | Log in | Español

Individuals & Families | Small Businesses | All Topics | SEARCH

Improving **HealthCare.gov**

The Health Insurance Marketplace online application isn't available from approximately 1 a.m. to 5 a.m. EST daily while we make improvements. Additional down times may be possible as we work to make things better. The rest of the site and the Marketplace call center remain available during these hours.

# Find health coverage that works for you

Get quality coverage at a price you can afford.
Open enrollment in the Health Insurance Marketplace continues until March 31, 2014.

**APPLY ONLINE**

**APPLY BY PHONE**

# Subscriber Card


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# Eligibility Verification

Member:

This card does not guarantee coverage. To verify benefits, view claims or find a provider, visit MDwiseMarketplace.org or call customer service.
EMERGENCIES: Call 911 or go to the nearest Emergency Room; must notify MDwise within 48 hours after admittance.
Pharmacy member services helpline: 1.855.491.0632

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Provider:

Check member eligibility every visit at MDwise.org/provider
Pharmacy: 1.855.491.0633 • Pharmacy BIN: 600248, PCN 06590000.
VSP Vision Care (child benefit only): 1.855.868.4561

| WebMD/EMDEON | McKesson/Relay Health |
|---|---|
| Institutional Payer ID: 12K81 | Institutional Payer ID: 4976 |
| Professional Payer ID: SX172 | Professional Payer ID: 4481 |

Claims Address: MDwise, P.O. Box 830120, Birmingham, AL 35283-0120

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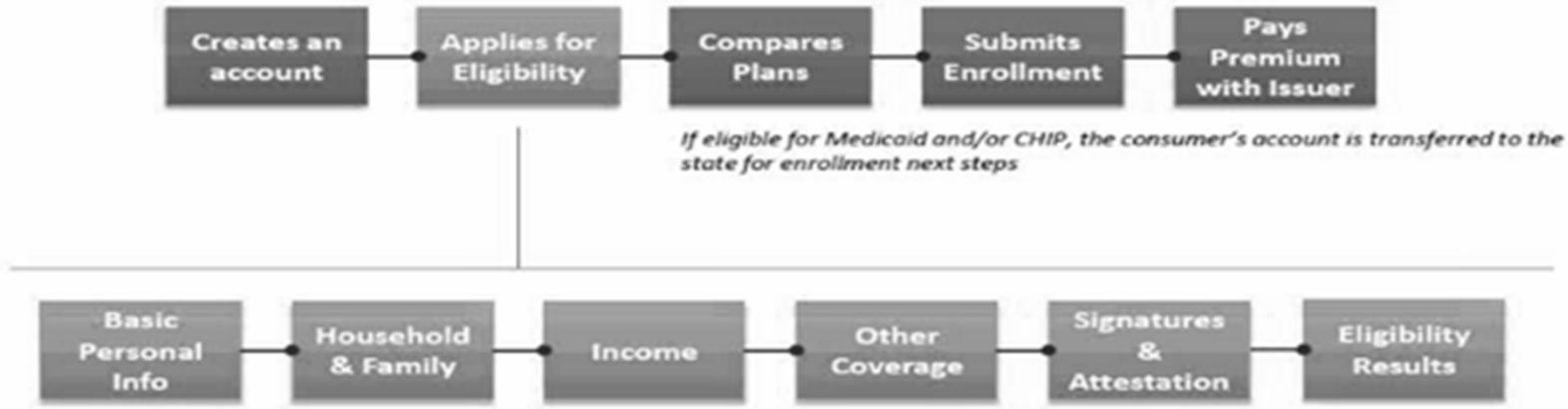
# Member Enrollment and Eligibility

- **The Marketplace is responsible for all eligibility determinations.**
- The Marketplace enabled individuals and families to have their eligibility determined for all insurance affordability programs through a single, streamlined process. This process includes:
  - Eligibility check for the Marketplace or Medicaid
  - Amount of potential "help paying for coverage"



## Member Enrollment and Eligibility

- Consumers must meet the following criteria to be eligible for a health plan on the Marketplace:
  - Under age 65.
  - Residing in Our Service Area.
  - A legal resident of Indiana.
  - Eligible for Coverage on the Marketplace.
  - Not eligible for or enrolled in Medicare, Medicaid or CHIP.
- Providers will verify consumer eligibility using the MDwise Web Portal.
- Members will receive a MDwise health plan card, but providers must still verify eligibility on the MDwise Web Portal.

# Grace Periods

- **Grace Periods for Member Premium Payments**

  The ACA permits a grace period for members whose premiums are past due. The grace periods are different depending on whether or not the member gets federal subsidies to help them pay their monthly premiums (Advanced Premium Tax Credits, also known as APTC).

- **For non-subsidized members, the grace period is one month.** This grace period shall not extend beyond the date the member's policy terminates. Any claims incurred and submitted during the grace period will be pended until premium is received. If premium is not received within the grace period, claims incurred during the grace period will be denied and the member's coverage will automatically terminate retroactive to the last paid date of Coverage.

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## Grace Periods

- **For subsidized members, the grace period is three months.** MDwise will pay all appropriate claims for services in the first month of the grace period and may pend claims for services in the second and third months of the grace period. Any claims incurred and submitted during the latter two months of the grace period will be pended until the member becomes current on their premiums, or until the end of the grace period, whichever comes first. If payment is not received by the end of the grace period, the member's coverage will automatically terminate retroactive to the last day of the first month of the grace period.

## Tiered Network

- PMP selection determines Tier 1 network. This is the risk-bearing Delivery System.
- All other MDwise providers are considered Tier 2, where the member would experience higher cost sharing.
- PA is not required to see a Tier 2 provider, unless the particular service requires a PA.

Individual selects MDwise on the Exchange

MDwise onboards the new member and has them select their PMP

PMP choice determines member's risk bearing Delivery System **and "tier 1" network**

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# Tiered Model

| Tier | Defined as | Member cost sharing example: Lab (Silver 70%) |
|---|---|---|
| Tier 1 | All providers in the PMP's delivery system | $40 (applicable to deductible) |
| Tier 2 | All other MDwise providers (who are contracted with other delivery systems) | $80 (applicable to deductible) |
| Out of Network | Non-participating providers – very limited benefit per law (i.e. emergency care) | Not covered unless required by Marketplace (ACA) or provider receives prior authorization |

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## How do the Tiered benefits affect the Contract?

- The provider contract obligates the provider to see both Tier 1 and Tier 2 members.
- What rate is paid if provider is Tier 2 for that member?
  - Provider will be paid at their contracted Tier 1 rate, but with Tier 2 member cost-sharing applied.
  - If provider has more than one Tier 1 contract (i.e. has signed with multiple delivery systems), then for Tier 2 services provided, the lowest Tier 1 contract rate will apply (but with Tier 2 member cost sharing)

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# Example

| | |
|---|---|
| **Dr. Smith's contracts:** | • **Hoosier Alliance – 100%**<br>• **IU Health – 105%**<br>• **Select Health – No contract (Tier 2)** |

| **What do we pay for each member who presents to Dr. Smith?** | |
|---|---|
| **HA member** | Dr. Smith is a Tier 1 provider so:<br>Pay 100%, Tier 1 cost sharing/deductible |
| **IU Health member** | Dr. Smith is a Tier 1 provider so:<br>Pay 105%, Tier 1 cost sharing/deductible |
| **Select Health member** | Dr. Smith is a Tier 2 provider so:<br>Pay 100%, Tier 2 cost sharing/deductible |

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## Non-Participating Providers

- What if a member sees a Non-Participating provider (i.e. what if I don't sign with any MDwise delivery system but I still see your member)?
  - Emergency services by Non-Participating providers will be paid as required by the ACA (with applicable member cost sharing)
  - Other services by Non-Participating providers:
    - These will only be paid if PA is obtained because the service cannot be provided by an in-network provider.
    - Payment is limited to the allowed amount for the lowest MDwise QHP rate in Indiana, with member cost sharing applied, because the service was not available in-network. Any additional charges by the provider would be the member's responsibility.

## PMP Rules

- A provider can participate as a specialist in multiple delivery systems, but can only serve as a PMP in one Delivery System.
- We will not use panel limits for Marketplace.
  - Providers will indicate that their practice is "Open" if they are accepting new patients, but not indicate a specific number of panel slots.
  - There will be a Panel Add process for a "Closed" practice to add a specific member.
- PMPs can have patients assigned to them at multiple locations (no limit).
- Referrals are not required to see a specialist but prior authorization may apply for certain services.

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## Autoassignment

- MDwise will onboard each new member (through outbound calls, new member mailings) and help them select a PMP.
- Autoassignment will be used to assign a PMP if a member does not self-select a PMP within 30 days of becoming eligible.
- We will assign based on multiple factors including provider specialty type, age restriction, and mileage.

# Member PMP changes

- MDwise will then assist the member in selecting a new PMP within the MDwise network of physicians. Marketplace members may only change their PMP three times each year, except for the following:
- Member has moved.
- PMP has moved or is no longer contracted with MDwise.
- Access related issues with PMP (e.g. has trouble getting appointments with PMP)
- Quality of care concerns
- PMP was auto-assigned to member
- Life changing events as defined by CCIIO guidance
- Following PMP initiated member reassignment

## Member PMP changes continued

- PMP changes within a Delivery System are effective within one business day of member request being entered by Customer Service Specialist into the Customer Service System.
- PMP changes between Delivery Systems will always be effective on the 1st depending on the date of input. The data entry cutoff date for PMP changes is the 25th of each month. *Note: This date may vary if the 25th falls on a weekend or holiday.* For example, a PMP change entered on July 18th will be effective on August 1st. A PMP change entered on July 30th will be effective on September 1st.

## MDwise Care Management

- MDwise will have a care management program designed to provide member and provider interventions to help meet member health needs and manage chronic conditions as well as be NCQA compliant.
- Each member upon enrollment in the MDwise Marketplace product will be asked to complete an Health Risk Screener.
  - Based on the results of the HRS and other stratification metrics, MDwise and our Delivery Systems will interact with Members and Providers telephonically, in print, and online about our care management/ disease management programs.

## Care Management

The goals of the MDwise disease management/care management programs include:

- Promote prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies
- Support the provider and member relationship
- Provide member access to educational resources regarding his/her diagnosis or chronic conditions
- Promote healthy lifestyle choices, address barriers to care, and provide access to resources
- Empower the member to actively participate in his/her healthcare management

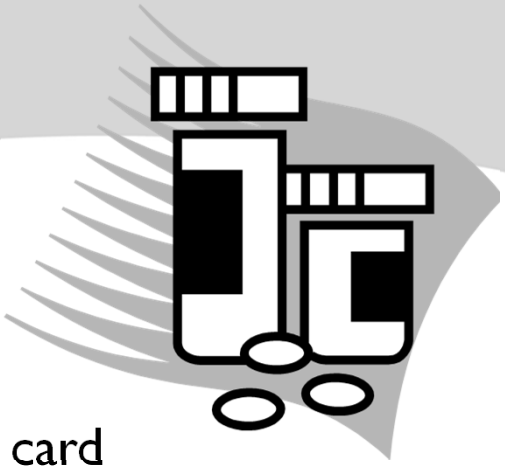
## Medical Management

- A sample of services that require a PA:
  - Transplants
  - Prosthetics, Orthotics, Diabetic supplies and DME
  - Hospice
  - Home Health nursing
  - Behavioral Health substance abuse services (inpatient or outpatient)
  - Certain pharmaceuticals (PDL will be posted on website)
  - All services by out-of-network providers
  - Tier 2 or out-of-network provider wanting to be seen as a Tier 1 provider (due to access issues)
- The complete Prior Authorization list is available at MDwise.org/for-providers/forms/prior-authorization/

## Medical Management

- Appeals
  - Providers may appeal a PA denial based on medical necessity or an administrative denial reason.
  - A provider who delivers a service that requires PA without obtaining the necessary PA prior to service delivery, risks nonpayment from MDwise regardless of medical necessity.
  - Providers can refer to the PA Reference Guide for additional information regarding appeals located at www.mdwise.org.

## Pharmacy & Formulary



- PerformRx is MDwise's pharmacy benefit manager.
- PerformRx is identified on the MDwise Marketplace ID card
- In the MDwise Marketplace Formulary, clinicians can search our database for:
  - Drug coverage under a member's plan
  - Drug tier copay
  - Prior authorization
  - Mail Order Program
  - 90 Day Program
- Formulary is now available at http://www.mdwise.org/for-providers/tools-and-resources/pharmacy-resources/mdwise-marketplace/.
- MDwise members can order a 90-day supply of certain prescription drugs through Walgreen's Mail Service Pharmacy.

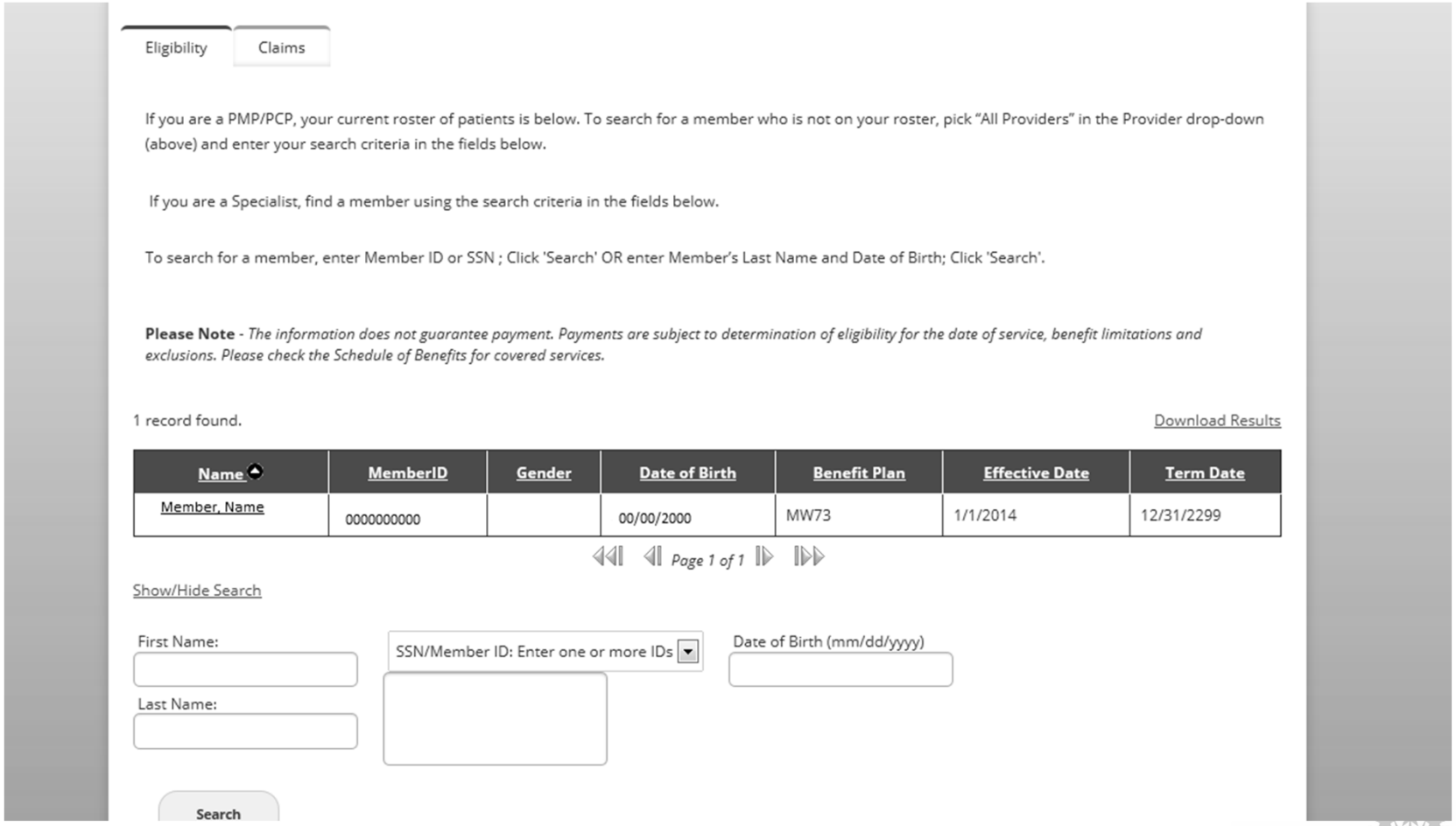
## Behavioral Health

- MDwise Corporate contracts and credential the Behavioral Health providers as a centralized network.
- Mid-level providers are paid under the normal Medicare fee schedule but with reductions applied as permitted by Medicare and MDwise Marketplace payment policies.
- Behavioral Health Triage & Referral:
  - MDwise maintains a 24-hour triage and referral service that can be accessed through the MDwise  Customer Service number.

## Eligibility Verification

- Providers can check a Marketplace member's eligibility and view their summary of benefits on the MDwise web portal at MDwise.org.
- This is a free service to all providers, however each individual user must sign up for an account at MDwise.org/for-providers/mymdwise/.
- Providers will be able to view claims information on the web portal as well, for their specific Tax ID only (coming soon)
- Always check eligibility prior to providing services.
- Providers and members can also print the ID card from the portal.

# Eligibility Screen

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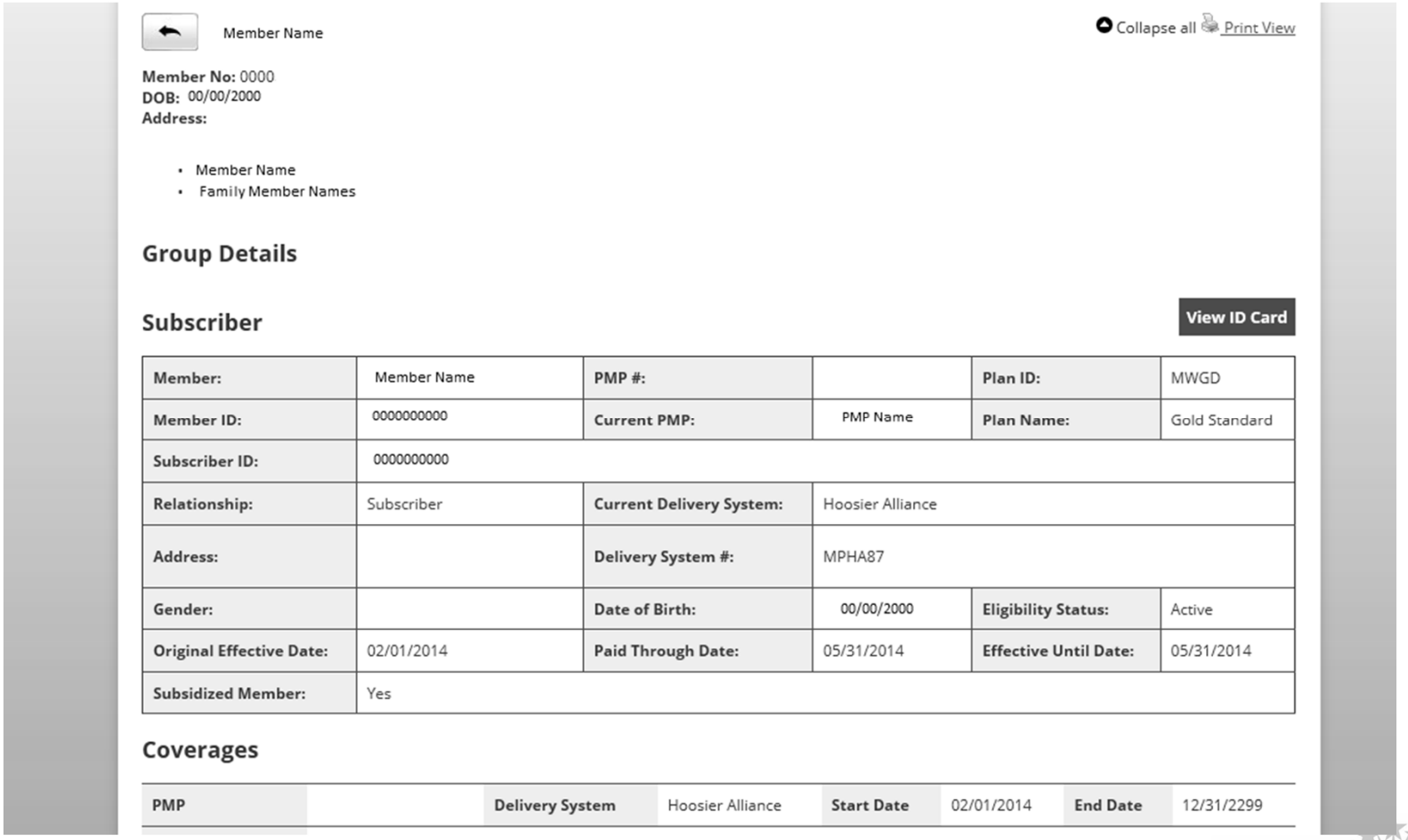
# Eligibility Screen continued



Member Name

Collapse all Print View

**Member No:** 0000
**DOB:** 00/00/2000
**Address:**

- Member Name
- Family Member Names

## Group Details

## Subscriber

View ID Card

| | | | | | |
|---|---|---|---|---|---|
| **Member:** | Member Name | **PMP #:** | | **Plan ID:** | MWGD |
| **Member ID:** | 0000000000 | **Current PMP:** | PMP Name | **Plan Name:** | Gold Standard |
| **Subscriber ID:** | 0000000000 | | | | |
| **Relationship:** | Subscriber | **Current Delivery System:** | Hoosier Alliance | | |
| **Address:** | | **Delivery System #:** | MPHA87 | | |
| **Gender:** | | **Date of Birth:** | 00/00/2000 | **Eligibility Status:** | Active |
| **Original Effective Date:** | 02/01/2014 | **Paid Through Date:** | 05/31/2014 | **Effective Until Date:** | 05/31/2014 |
| **Subsidized Member:** | Yes | | | | |

## Coverages

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **PMP** | | **Delivery System** | Hoosier Alliance | **Start Date** | 02/01/2014 | **End Date** | 12/31/2299 |

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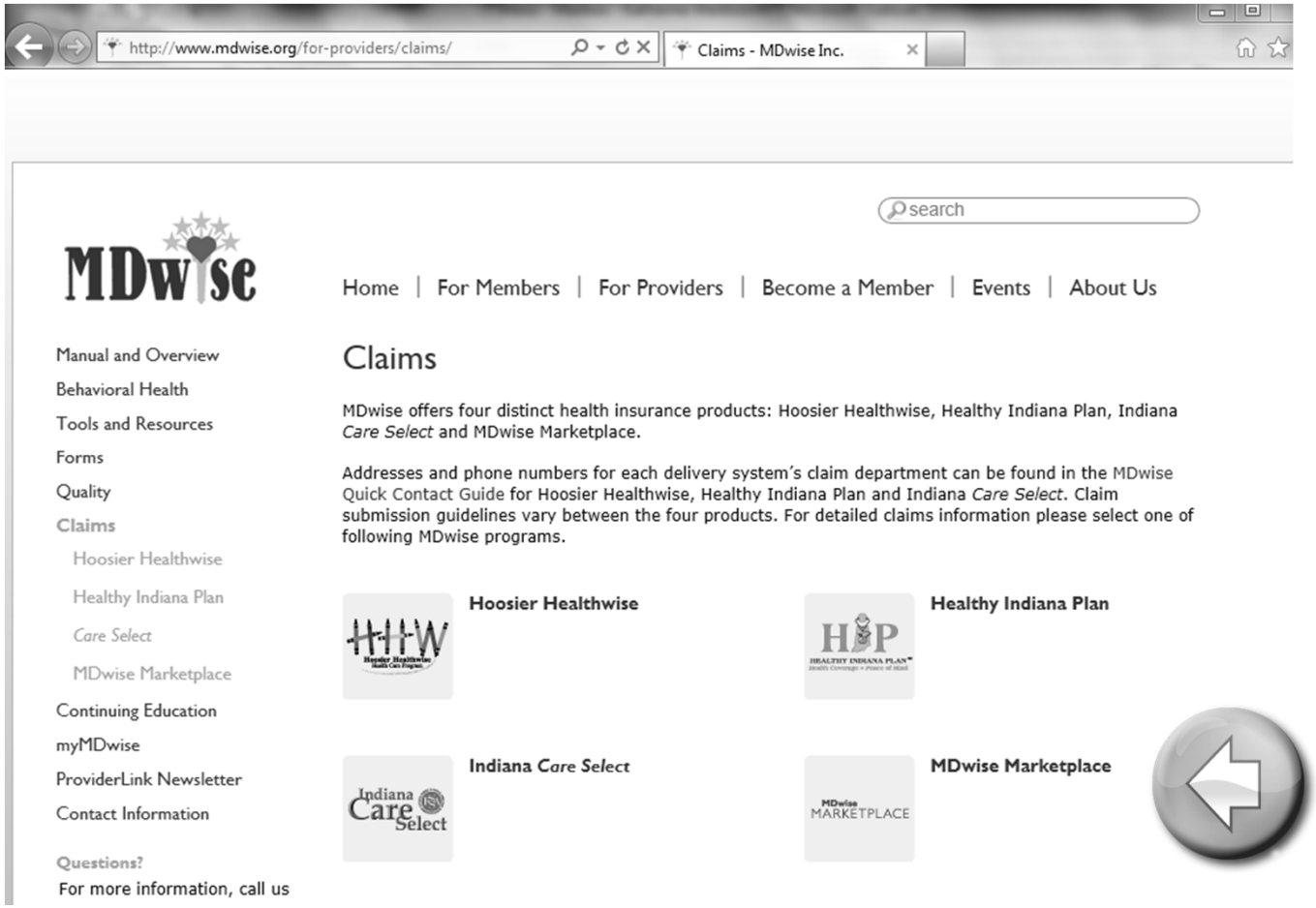
# Marketplace Claims Submission

- Claim submission guidelines vary between the four products.
- On the claims website page, click Marketplace to view details.

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## Claims - Continued

- **MDwise Marketplace Claims Information:**

  MDwise Marketplace claims are processed by DST.

  Claims should be mailed to:

  **MDwise Marketplace Claims**
  **P.O. Box 830120**
  **Birmingham, AL 35283-0120**

- For timely filing in-network claims must be submitted in 120 days of the date of service. For more information about Marketplace claims and submission guidelines, please see the Marketplace provider manual.
- Providers can view explanations of payment (EOP) electronically on our MDwise web portal starting July 1, 2014
- Prior authorization numbers, addresses, and electronic clearinghouse payer IDs can be found in our MDwise Marketplace quick contact guide.

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## Filing Limit

- Contracted providers (Tier 1)
  - Filing limit is 120 days
- Tier 2 providers/out of network providers
  - Filing limit is 180 days.
  - 180 days is also the filing limit for members who submit a member claim for an out-of-network service (rather than the provider submitting the claim).

# Claims disputes

## Informal Claims Dispute

- The provider must file an informal claims dispute within 60 calendar days after the provider has received an MDwise determination on the claim or within 90 calendar days of when the claim was submitted to MDwise, and MDwise fails to make a determination on claims payment.

- MDwise will acknowledge, in writing, the receipt of a request for a claim resolution review within 10 business days of receiving the dispute. MDwise will review the dispute and provide a written response to the provider. This response will be provided within 30 calendar days of the date the provider initiated the dispute.

# Claims dispute continued

**Formal Claims Dispute**

- If a provider is not satisfied with the resolution of the informal claim dispute, they may submit a written request for the matter to be reviewed in the formal claims dispute process. The request must specify the basis of the provider's dispute with MDwise. The provider is given 60 calendar days from the date of MDwise's initial claims review resolution response to file a formal claims dispute. MDwise acknowledges the dispute request in writing within 10 business days of receipt of the request.

- MDwise will issue a written reply to the provider's dispute within 45 calendar days of receipt of the written request. If MDwise fails to deliver the panel's written determination within 45 business days, this failure shall have the effect of an approval and the claim will be processed for payment within 30 business days.

## Claims Resolution

- Providers should call 855-417-5615 and ask to speak to a claims specialist if they have continuing questions about claims.
- If you require further escalation you can contact a MDwise provider relations representative at 317-822-7300 ext 5800

## Credentialing

- Credentialing must be completed before any participation/ reimbursement
- Requirements: Attestation, State License, Educational Requirements, Board Certification, Written Practice Agreement (if mid-level practitioner associated with licensed network practitioner)
- Credentialing begins with Universal CAQH application
- Recredentialing every 36 months
- Appeals procedures/rights given following adverse events

## Covered Preventative Services

- Preventive Care services include:
- Screenings and other Health Services are covered as Preventive Care for adults and children with no current symptoms or prior history of  a medical condition associated with that screening or service.
- Health Services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF) and subject to guidelines by the USPSTF.

## Covered Preventative Services

- Coverage of Preventive Care Services shall meet requirements as determined by federal and state law. **The following resources identify the preventative services covered by the act without cost sharing:**
- Services rated "A" or "B" by the US Preventive Services Task Force (USPSTF) (see Table 1) as posted annually on the Agency for Healthcare Research and Quality's Web site:

www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm

## Covered Preventative Services

- Coverage of Preventive Care Services shall meet requirements as determined by federal and state law. **The following resources identify the preventative services covered by the act without cost sharing:**
- Immunizations for routine use in children, adolescents, and adults as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

## Covered Preventative Services

- Coverage of Preventive Care Services shall meet requirements as determined by federal and state law. **The following resources identify the preventative services covered by the act without cost sharing:**
- Preventive care and screenings for children as recommended by Bright Futures (American Academy of Pediatrics) and Newborn Testing (American College of Medical Genetics) as supported by the Health Resources and Services Administration; and
- Preventive care and screenings provided for women (not included in the Task Force recommendations) in the comprehensive guidelines supported by the Health Resources and Services Administration.

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## Examples of Preventative Services

- Colonoscopy for 50-year old asymptomatic, CPT 45378, use preventative screening modifier 33, and well person diagnosis code V76.51.
- Visual impairment screening age 3 to 18, CPT 99173, use preventative screening modifier 33, and diagnosis code V20.2 or V70.0
- Please see our MDwise Marketplace reimbursement manual for more information about zero cost sharing preventative services.
- MDwise.org/for-providers/claims/mdwise-marketplace

## Incident to

- Per the Medicare Benefits Manual, Chapter 15, Section 60.1, incident to services "are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness."

- The physician or qualified non physician provider must have seen the patient previously for the problem or complaint for which the incident to service was provided. New patients, or those with a new problem, cannot be seen incident to.

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## Incident to

- Incident to coverage applies only to services that are medically appropriate to be done in the physician office.

- Incident to coverage is limited to situations in which there is direct physician supervision of auxiliary personnel. Direct supervision means the physician must be present in the office suite and immediately available to provide assistance and direction. The incident to service should be billed in the supervision physician's name.

# Questions?

Exclusively serving Indiana families since 1994.

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