Blue Cross of Idaho is dedicated to being the best choice for healthcare covered at competitive prices.

We will:
• Provide an exceptional customer experience
• Engage throughout our members’ healthcare journey
• Advocate on behalf of our members for outcomes-based, cost-effective healthcare

2015 Idaho Healthcare Conference

Provider Network Management
Agenda

- Provider Network Management Contacts
- Credentialing
- Physician Key Performance Indicators
- Ancillary Key Performance Indicators
- High Performance Networks
- True Blue Special Needs Plan Update
- ICD-10 Basic Validation
- Referring to In Network Providers
- Prior Authorization Process
- Medicare Advantage and the ABN
Provider Network Management

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- Stina Redford - Treasure Valley:  sredford@bcidaho.com  
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- Janie Tafoya - North Idaho:  jtafoya@bcidaho.com  
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- Becki Wallace - Independent Physician Clinics:  
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Provider Network Management
Commercial Ancillary

• Ambulance, Dental, Dialysis, Home IV, Limited DME, DME, Independent Clinical Lab, Prosthetics/Orthotics, Skilled Nursing Facilities
  • Sarah Hart – Provider Network Management Specialist
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• Chiropractic, Diagnostic Imaging, Home Health, Hospice, PT/OT/ST, Sleep Lab, Ambulatory Surgery Center
  • Leslie Hazen Meeks – Provider Network Management Specialist
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Provider Network Management
Commercial Ancillary

- Audiology, Dietician, Independent NP, Mental Health, Optometrist
  - Noelle Bruce – Provider Network Management
  - 208-985-1850  NBruce@bcidaho.com
Provider Network Management
Medicare/Medicaid Contracts

• Medicare Prime Services – Medicare Advantage
  • Hospitals, Physicians, Mental Health, PT/OT/ST, Skilled Nursing Facilities, Home Health, Laboratory and other ancillary
    • Lauri Rowell – Health System Performance Specialist
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• Medicaid Services – Special Needs Plan
  • Home and Community Based Services, Long Term Care, Medicaid Expanded Mental Health
    • Sheila Habblett – Provider Network Management Specialist
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Credentialing

- Credentialing is a requirement of HMO/Point of Service, PPO and Medicare Advantage provider contracts
- Signing a contract or completing a Provider Information Sheet does not equate to having passed credentialing.
- Providers must complete an Idaho Practitioner Application for professional providers or the appropriate facility type application
- Legibility and a complete application that includes all the required attachments is key
  - Applications that are not legible or are missing information can delay the process
Credentialing

• As of January 2015, any providers not yet credentialed
  • Remain non-contracting for Medicare Advantage
  • Will no longer appear in the Blue Cross of Idaho Provider Directory

• By the fall of 2015, providers who have not credentialed will likely be termed

• Hospital based and non-appointment based providers are not required to credential and do not display in the provider directory

• Credentialing for Physician Assistants who serve as Primary Care Providers has begun
Key Performance Indicators (KPI) Physician

• Blue Cross of Idaho is committed to improving the quality of care and services available to our members by promoting effective and efficient use of healthcare resources
• Effective July 1, 2015 the Key Performance Indicators are
  • Electronic Claims Submission Rate
  • Truven Clinic Cost Score
Key Performance Indicators (KPI)

Physician

Electronic Claims Submission Rate

- Clinics must meet or exceed the Electronic Claims Submission Rate of 90% to successfully meet this measure
- Performance will be measured using commercial claims processed with dates of service January 2014 through December 2014
- Clinics with 50 or fewer claims during this period will be assumed to have met the Electronic Claims Submission rate target
Key Performance Indicators (KPI) 
Physician

Exceptions

• Clinics may request reconsideration of their assigned fee schedule placement by providing a written detailed explanation detailing why they believe they have been assigned to the incorrect fee schedule within sixty days following fee schedule assignment

• Enclose copies of any relevant documentation and submit to the attention of Blue Cross of Idaho Provider Network Management

• Blue Cross of Idaho will respond to the Clinic in writing within thirty days of the decision and provide the reason for the decision
Ancillary Key Performance Indicators

Key Performance Indicators by provider type

- Audiologists, Independent Dieticians, Optometrists, Physical Therapy, Occupational Therapy, Speech Therapy
  - Electronic Claims Submission Rate
- Independent Nurse Practitioners
  - Electronic Claims Submission Rate
  - Generic Prescribing Rate
- Psychologists, Licensed Clinical Social Worker, Licensed CPC, Licensed Marriage and Family Counselors, and service extenders
  - Electronic Claims Submission Rate
  - Access to Care Attestation
Ancillary Key Performance Indicators

Ancillary Key Performance Indicators by provider type

- Chiropractor
  - Electronic Claims Submission Rate
  - Compliance with Data Entry Requirements for

- Electronic Claims Submission Rate for All Ancillary Providers
  - Electronic Claims Submission Rates of 90% or higher will meet this measurement
  - Performance will be measured using commercial claims processed with dates of service specified in your contract
  - Clinics with 32 or fewer claims during this period will be assumed to have met the Electronic Claims Submission Rate target
Ancillary Key Performance Indicators

Appeal for Exception for all Ancillary Providers

- Clinics may request reconsideration of their assigned fee schedule placement by providing a written detailed explanation detailing why they believe they have been assigned to the incorrect fee schedule utilizing the Inquiry and Claims Appeal Process found in the contract.
High Performance Networks

- Blue Cross of Idaho partners with Provider Networks to provide a new model of healthcare delivery that more tightly aligns physicians, hospitals, and payers to provide better clinical quality while providing medical care at an affordable price
  - High Performance Provider Network
  - Limited Service Areas
  - Members are required to select a Primary Care Physician
  - Unique Alpha Prefix
  - Network ID on ID Card
  - Co-branded ID Cards for Commercial
  - Available on and off the Exchange
  - Commercial and Medicare Advantage Plans
High Performance Networks

• High Performance Policies and Plans have been available in Idaho for the past 2-3 years in varying markets
• Blue Cross continues to work with other provider networks to create additional options for members
• These efforts are statewide and ongoing
• Current plans are titled *ConnectedCare*, but additional plans have varying names especially in a market area that has overlapping options
• Members have higher cost share for providers who are not within the network
ConnectedCare™ – Commercial Plans

Saint Alphonsus Health Alliance

• Network ID SAHA
• Logo on ID Card with red accent
• Available to members residing in:
  • Ada, Canyon, Gem, Payette, and Washington counties in Idaho and Malheur County Oregon.

Portneuf Quality Alliance

• Network ID PQA
• Logo on ID Card has orange accent
• Available to members residing in:
  • Bannock and Bingham counties
True Blue Connected Care – Medicare Advantage

- Saint Alphonsus Health Alliance
  - Network ID SAHA in red on ID Card
  - PCP Name in red on ID Card
  - Available to members residing in:
    - Ada, Canyon, Gem and Payette counties
- Providers who are not part of the SAHA Contract for True Blue Connected Care are not in network.
  - Members require prior authorization for services performed by non-contracting providers, with the exception of urgent and emergent services
True Blue Special Needs Plan

• Plan began in April 2006
  • Expansion of services July 1, 2014
    • Provides coverage of A & D Waiver Services
      • Home and Community Based Services (HCBS)
      • Long Term Services and Supports (LTSS)
    • Provides expanded mental health coverage
      • Community Based Rehab Services, Targeted Case Management and adding Peer Support in July of 2015
  • Every Member has access to a Care Manager
  • Alpha Prefix Change to XMX to better identify this population
  • Offered in 33 counties in Idaho for 2015
    • Ada, Adams, Bannock, Benewah, Bingham, Blaine, Boise, Bonner, Bonneville, Boundary, Canyon, Caribou, Cassia, Clark, Elmore, Fremont, Gem, Gooding, Jefferson, Jerome, Kootenai, Latah, Madison, Minidoka, Nez Perce, Oneida, Owyhee, Payette, Power, Shoshone, Twin Falls, Valley and Washington
True Blue Special Needs Plan –
Long Term Support Service

- Adult Day Health
- Day Habilitation
- Homemaker Services
- Residential Habilitation
- Respite Care
- Attendant Care
- Adult Residential Care
- Chore Service
- Companion Services
- Consultation Services/FI
- Expanded Dental Services
- Residential Assisted Living Facilities

- Environmental Accessibility Adaptations
- Home Delivered Meals
- Non-medical Transportation
- Personal Care Services
- Personal Emergency Response System
- Skilled Nursing
- Specialized Medical Equipment and Supplies
- Supported Employment

**True Blue Special Needs Plan also covers Targeted Service Coordination for eligible members on the**
ICD-10 Basic Claim Validation

• Beginning in April 2015, Blue Cross of Idaho will allow our trading partners to send test ICD-10 claims for basic validation
• The testing will not be end-to-end, but will validate that the transactions are properly formatted for processing
• Providers who wish to test the new system need to contact the EDI Help Desk for a test account. You’ll submit ICD-10 claims through the system and we will return results to your account within 10 working days
• You may call the EDI Helpdesk at 888-224-3341 opt 2 for a test account
Referral to In-Network Providers

• When a contracting provider refers a member to another provider, it should be another contracting Covered Provider
• Continued referrals to out of network Covered Providers may, after appropriate notice, subject the referring provider to the following administrative actions for failure to comply
  • Decrease in fee schedule; or
  • Termination or suspension of network participation
Prior Authorization Process

• Prior Authorization has been a requirement of the provider contract for many years
• Effective May 1, 2015, failure to obtain pre-service approval for any service that requires prior authorization will result in claim non-payment and provider liability for our commercial products
• Obtaining authorization prior to service delivery is the optimal practice in order to
  • Avoid Provider financial risk
  • Assist BCI in determining medical necessity before services and resources are expended
  • Informs members of potential responsibility prior to services being rendered
Prior Authorization Process

- Authorization process can be found in PAP 241 Prior Authorization Requirements
- JIVA Portal is the most efficient way to submit requests for medical, pharmacy and behavioral health authorizations
- AIM Portal is available for advanced imaging and sleep testing and therapy
- Please submit medical records supporting the medical necessity of your request at the time of the authorization submission to ensure timely review
Prior Authorization Process

For Urgent Requests, please refer identify on the request that the service is urgent

• **Definition of urgent care** – Urgent care is any request for medical care or treatment which the time periods for making non-urgent care determinations could result in the following circumstances:
  • Could seriously jeopardize the life or health of the member or the ability to regain maximum function, based on a prudent layperson's judgment, or
  • In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.
Medicare Advantage and the ABN

- In May of 2014, CMS implemented new rules surrounding the discontinued use of the Advanced Beneficiary Notice (ABN) and the use of ABN modifiers for Medicare Advantage Plans
- Any services billed with an ABN modifier will be processed based on the following guidelines:
  - Services that are non-covered as an exclusion of the member EOC or statutory exclusion by CMS, will be processed to deny as member liability
  - Services that are not identified as a non-covered exclusion of the Member EOC or statutorily non-covered by CMS, will be denied as provider liability unless an organizational determination is obtained prior to services being rendered. If an organizational determination is on file for a service and determined to be non-covered, claim will process the denial as member liability.
Medicare Advantage and the ABN

- NCD Labs will require an organizational determination unless the test meets the CMS covered criteria. NCD lab(s) that do not meet the CMS criteria and an organizational determination was not obtained, will deny provider liability.
- Services that require prior authorization and authorization is not obtained, services will deny as provider liability.
Questions?