American Association of Healthcare Administrative Management
All Payers Session
June 7, 2019

nh healthy families™

6/10/2019

Outline

- First Quarter Enhancements
- Credentialing/Re-Credentialing/ Demographic Updates
- Claims
- Prior Authorization
- Member Eligibility
- Website & Secure Portal Tools
- Provider Engagement Tools
- Risk Adjustment
- Network Adequacy & Availability
- Quality Improvement Updates
- Notification of Pregnancy/Prenatal Vitamins

First Quarter Enhancements

- Change to Explanation of Benefits
- Authorization Changes for PT/OT/ST
- Claims Tracker

Changes Coming-2019

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- Submit reconsiderations online & view/filter reconsideration status
- Receive online notification when reconsideration has been received or upheld
- Upload attachments and add comments to reconsiderations
- View more claim details: check number, date, check amount and denial reason descriptions
- Improved Provider grievance and appeals processes

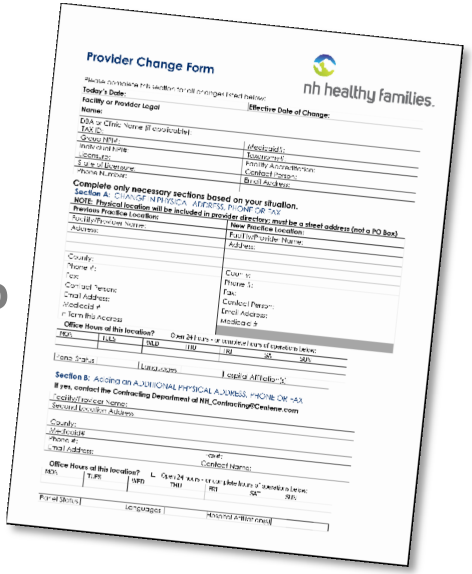
Credentialing & Re-credentialing

Credentialing & Demographic Updates

The Network Operations team is available to process the following requests:

- Initiate credentialing of a new practitioner
- Demographic updates
- Reconcile rosters
- Provider additions & terminations to your practice

Use Provider Change Form under "Provider Resources" on website and follow instructions for sending change to NH Healthy Families


Provider Change Form
nh healthy families.

- To inquire on the credentialing status of a provider, email: providerupdatesnh@centene.com

Re-Credentialing

RE-CREDENTIALING:

WHAT IS IT?

NH Healthy Families re-credentials each practitioner's file every 36 months in an effort to ensure standards are continuing to be met for participation in NH Healthy Families' network. To complete re-credentialing, the application and attestation, or verification of information, must be signed and dated within 120 days of your re-credentialing notification. For some practitioners, hard copies of documentation may need to be sent to the health plan for re-credentialing.

Credentialing/Re-Credentialing

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KEEP US IN THE LOOP

We understand that you may experience changes to your roster after credentialing is completed. In an effort to keep our system up to date, **please inform our team as your roster changes and confirm your Provider TIN, hospital affiliations, Member panel, and provider email addresses.**

You may receive requests from us regarding any changes to your roster and to provide a Provider Change Form, which is available online or in the Orientation Packet you received when becoming a partner in our network. Please respond timely if any changes have occurred.

LET'S STICK TOGETHER

We want you to provide care to your patients and our members as seamlessly as possible during our transition to HCAS. We appreciate your patience and diligence to complete the credentialing and re-credentialing processes.

Thank you!

Claims

Timely Filing - Claims

Product	First Time Claims	Reconsiderations (written request from provider about a disagreement with the way a claim processed)	Disputes (written request from provider used only when a provider has received an unsatisfactory response to a request for reconsideration)
NH Healthy Families	Claims will not be accepted over **90 calendar days** from the date of service for medical providers or more than **365 calendar days** from the date of service for BH/SUD providers.	**180 calendar days** from the date of the Explanation of Payment (EOP) and cannot ***exceed 15 months from the date of service.***	**180 calendar days** from the date of the Explanation of Payment (EOP) and cannot ***exceed 15 months from the date of service.***
Ambetter	Claims will not be accepted over **180 calendar days** from the date of service	**180 calendar days** from the date of the Explanation of Payment (EOP)	**180 calendar days** of the date from the Explanation of Payment (EOP)

Claims Submission

Claims may be submitted in 3 ways:

Submission Type	NH Healthy Families	Ambetter
Secure Web Portal	www.nhhealthyfamilies.com	www.ambetter.nhhealthyfamilies.com
Electronic Clearinghouse	Medical – 68069 Behavioral Health -68068	Medical & Behavioral Health - 68069
Original Paper & Corrected Claims	**Medical Claims** NH Healthy Families Attn: Claims Department P.O. BOX 4060 Farmington, Missouri 63640-3831 **BH/SUD Claims** NH Healthy Families Attn: Claims Department P.O. BOX 7500 Farmington, Missouri 63640-3830	Claims Department PO Box 5010 Farmington, MO 63640-5010

EDI Contact: 800-225-2573 ext. 25525 - E-mail: EDIBA@centene.com

NH Healthy Families accepts both electronic (EDI) and paper claims

Claims Rejections

- For EDI claims, rejections happen through one of our EDI clearinghouses if the appropriate information is not contained on the claim.
- For paper claims, rejections occur prior to the claims being scanned in the claims adjudication system and will be sent to the provider with a letter detailing the reason(s) for the rejection.
- A denial occurs after the claim has been received into the claims adjudication system and will be sent to the provider via an Explanation of Payment (EOP) or Electronic Remittance Advice (ERA).
- Claims for billable services provided to NH Healthy Families members must be submitted by the provider who performed the services or by the provider's authorized billing vendor.

Questions about rejected electronic claims?
EDI Contact: 800-225-2573 ext. 25525 - E-mail: EDIBA@centene.com

Top 5 Claim Denials

Top 5 Claim Denials

1. EX18-Deny: Duplicate Claim Service

Before submitting claims:

- Verify if a modifier is necessary to indicate a procedure or service was repeated
- Allow 30 days from the claim receipt date for the claim to process before resubmitting
- Verify the reason the initial claim did not allow payment-if resubmission is necessary send a corrected claim

Top 5 Claim Denials, (con't.)

2. EXOB-Adjust: Claim to be reprocessed or corrected under a new claim number

– This EX code is used to inform the provider that the original claim is adjusted under a new claim number.

Top 5 Claim Denials, (con't.)

3. EXDS-Deny: Duplicate Submission-original claim still in pend status

- Denial occurs when a claim is in process and the provider submits the claim again
  - Submission could be a new original claim
  - Submission could be a corrected claim
- Allow a claim to complete processing prior to resubmitting the claim

Top 5 Claim Denials,(con't.)

4. EX16-Bill Primary Ins First. Resubmit with EOB or Insurance Explanation code

- Provider bills NH Healthy Families Primary and the patient has other insurance
- COB rules=Medicaid which includes Medicaid MCO Plans are always the payer of last resort

Top 5 Claim Denials,(con't.)

5. EX 28-Deny: Member not eligible on DOS

   – Minimize this denial by performing an eligibility check prior to the service date

PaySpan Health EFT/ERA

- PaySpan Health is a secure, self-service website which can be utilized to manage and receive electronic payment and remittance advice.
- Manage and access remittance data 24 hours a day
- For more information please contact PaySpanHealth at 800-733-0908, www.payspanhealth.com or contact PCSC@payspan.com
- Register to attend a free webinar by calling 877-331-7154 or e-mail PaySpan at providersupport@payspanhealth.com

Prior Authorization

Prior Authorization Submission Requirements

Type of Service	Authorization Requirement
Elective or scheduled admissions	Notification 5 days prior to admission
Urgent or emergent admission	Notification within 1 business day following the admission
Requests for services at a tertiary facility or with a tertiary provider	Authorization required when such services are available in the community setting
Outpatient services including outpatient rehab services (PT, OT, ST)	Authorization required after the initial evaluation
Services rendered in the home	Authorization required
Hospice Care	Authorization required
Some Specialist Services	Verify authorization requirements using the Pre-Screening Tool
High-Tech Imaging	Verify authorization requirements using the Pre-Screening Tool – Managed by NIA, request authorization at: www.radmd.com
All out-of-network services	Authorization required

Please refer to the NH Healthy Families Pre-Screening Tool accessible via the Provider Resources page at www.nhhealthyfamilies.com & www.ambetter.nhhealthyfamiilies.com

Prior Authorization Submission Requirements

NH Healthy Families Prior Authorization can be requested the following ways:

1. Via the NH Healthy Families secure portal
   - NH Healthy Families: www.nhhealthyfamilies.com
   - Ambetter: ambetter.nhhealthyfamilies.com

2. Fax Prior Authorization Requests to:
   - NH Healthy Families:
     - Medical: 866-270-8027
     - Inpatient Admission: 877-291-3140
     - Concurrent Review: 877-295-7682
   - Ambetter: 1-844-430-4485

3. Call for Prior Authorization at:
   - NH Healthy Families: 1-866-769-3085
   - Ambetter: 1-877-687-1186

4. For PT/OT/ST Services:
   - GO to the NIA website: www.radmd.com
   - Call: 1-866-769-3085

Prior Authorization Forms can be found on the Provider Resource Page at www.nhhealthyfamilies.com & www.ambetter.nhhealthyfamiilies.com

PA Type	Processing Time
Urgent/Expedited	72 hours
Standard PA	14 calendar days

Important Reminders
NH Healthy Families utilizes InterQual® Criteria
Written or electronic notification of the authorization request will be sent to the provider
Be sure to request Authorizations using the NPI number that will be billed on the claim
Complete information regarding the services or procedures being requested
Failure to obtain authorization may result in an administrative denial, and Providers are prohibited from holding a Member financially responsible.

Member Eligibility

Member ID Card

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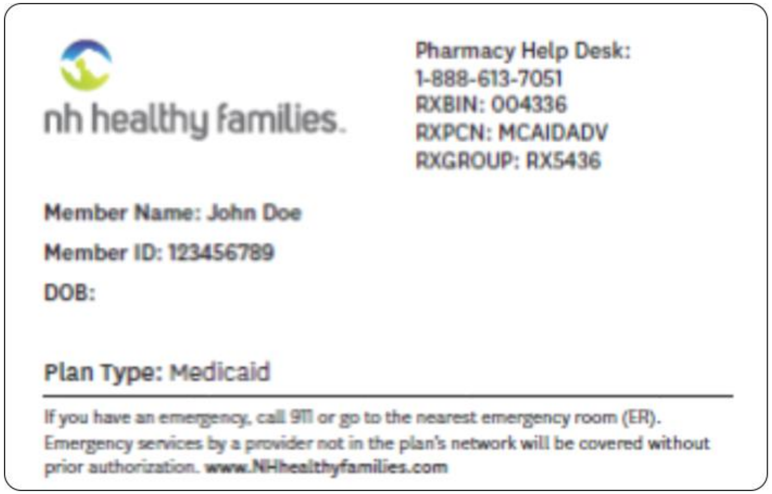
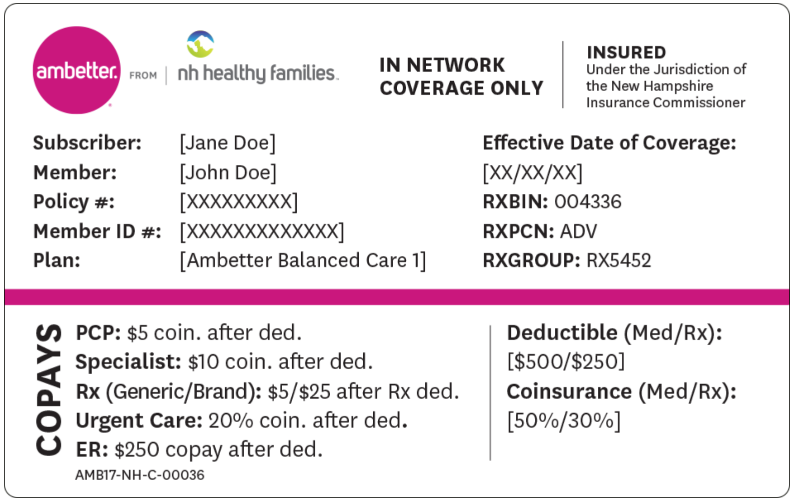
Medicaid/Granite Advantage Healthcare Program



Ambetter



Verification of Eligibility

Verify Eligibility by checking one of the systems below at the time of each visit, as well as, daily during an inpatient hospital stay.

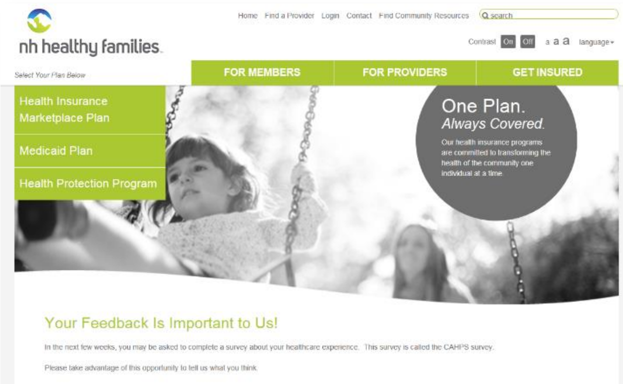
- **Secure Portal** - Verify eligibility at www.nhhealthyfamilies.com
- **Provider Service Call Center** - Verify eligibility Monday through Friday, 8:00 am to 5:00 pm (EST) or 24/7 using the Interactive Voice Response system (IVR) at:
  - NH Healthy Families: **1-866-769-3085**
  - Ambetter: **1-844-265-1278**
- **NH MMIS Health Enterprise portal –** Verify eligibility for Medicaid and Granite Advantage members at: www.nhmmis.nh.gov

Website and Secure Portal Tools

Web-Based Tools

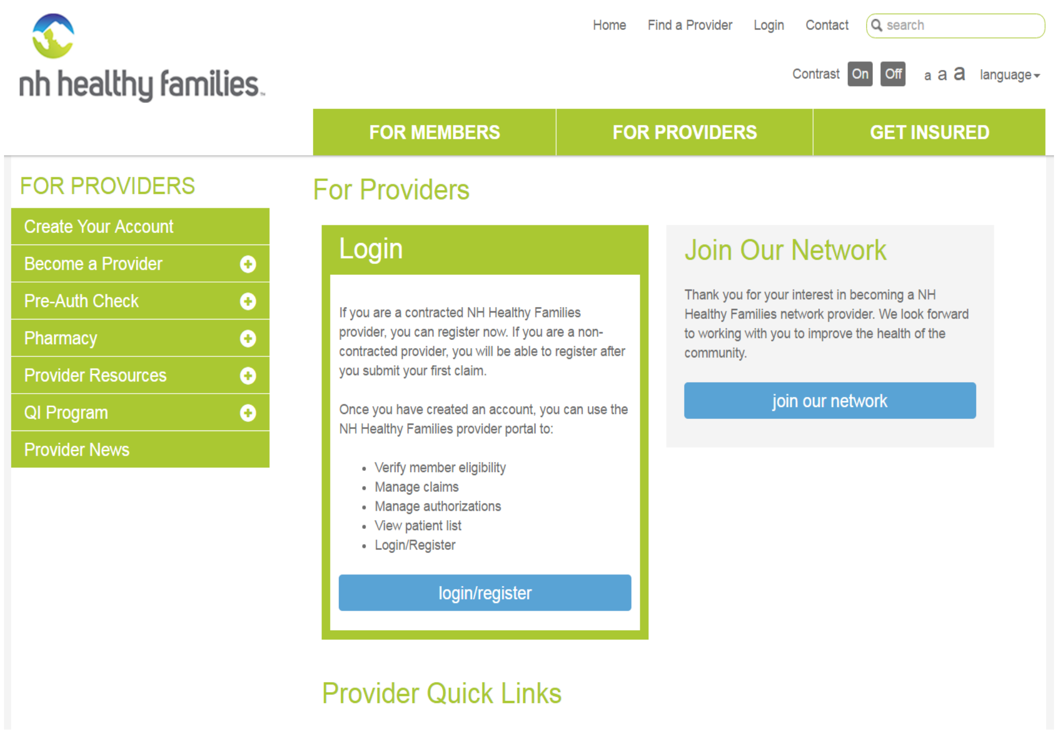
Web-Based Tools

- Public site at www.NHhealthyfamilies.com & ambetter.nhhealthyfamilies.com
  - Provider Manual and Billing Manual
  - Provider Information for Medical Services
  - Prior Authorization Code Checker
  - Operational forms such as Prior Authorization Forms, Notification of Pregnancy forms, etc…
  - Clinical Practice Guidelines
  - Provider Newsletters and Announcements
  - Plan News
  - Find a Provider



- NH Healthy Families is committed to enhancing our web based tools and technology!

Provider Secure Portal



Through the Secure Web Portal Providers can:

- Check Member Eligibility
- Submit Prior Authorization Requests
- View Patient Lists and Care Gaps
- Submit, view and adjust claims
- View Payment History
- Detailed patient & population level reporting
- Pay for performance, Cost and Utilization Reporting tool

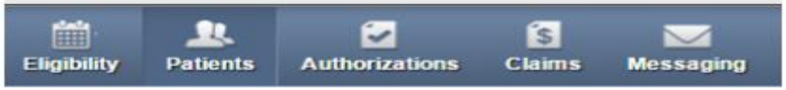
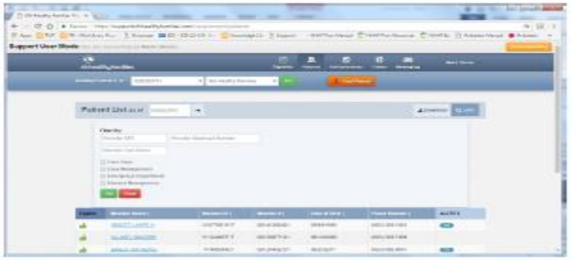
Registering is easy!

- Must be a participating provider or if non-participating, must have submitted a claim

Patient Panel Maintenance

Pulling Member Panel via Provider Secure Portal

Procedure: Follow these steps to pull the patient panel via the NH Healthy Families & Ambetter Provider Secure Portal.

Step	Action
1.	Login to your secure web portal account via nhhealthyfamilies.com – "Provider Login"
2.	Once you are logged in, Select "Patients" using the top menu ribbon 
3.	Once under the "Patients" section within the portal, click "Filter" 
4.	Enter the Practictioner's NPI in the "Provider NPI" field under "Filter By" and click "GO" 
5.	Once the list is displayed, click "Download" 
6.	By selecting "Download" the patient list will automatically download the entire patient list as of the date entered (will default to todays date) via excel. NOTE: If the provider is not able to see the download, check the pop up blocker as this may prevent the download from appearing.

Patient Panel Maintenance

Member/Patient Panel Maintenance

1. For members never seen at the Primary Care Practice based on the membership panel report:
Outcome: All members are established with their primary care providers

Step #	Primary Care Practice steps	NH Healthy Families steps
1A	Generate entire panel report via Provider Portal reports periodically. Compare list to patients in the EMR. Identify patients on the list never seen at the Primary Care Practice.	Consult with Provider relations to generate a report.
1B	Attempt (2 CALLS & 1 LETTER) to contact patient to schedule an appointment.	See instruction on page 3 titled "Pulling Member Panel via Provider Secure Portal." Consult Provider Relations for questions nhproviderrelations@centene.com
1C	If you have no contact information for members, reach out to NH Healthy Families Member Services 1-866-769-3085.	
1D	Or… If attempts to contact member fail - Send Referral to Member Connections using the request form on the NH Healthy Families website: nhhealthyfamilies.com	Member Connections will attempt outreach and notify referring provider the status of the outreach so they can update system of changes if applicable. If contacted and member indicates they have a PCP in another practice, Member Connections will make any pcp changes and inform practices.
1E	If contacted patients who indicate they have another PCP need to fill out a PCP Change Form and mail it to NH Healthy Families or call NH Healthy Families to make that change. Provider Portal has most up to date address for the patients.	

2. Terminating providers listed as PCP who are no longer at the primary care practice:
Outcome: Remove pcp from directory and reassign members to another pcp

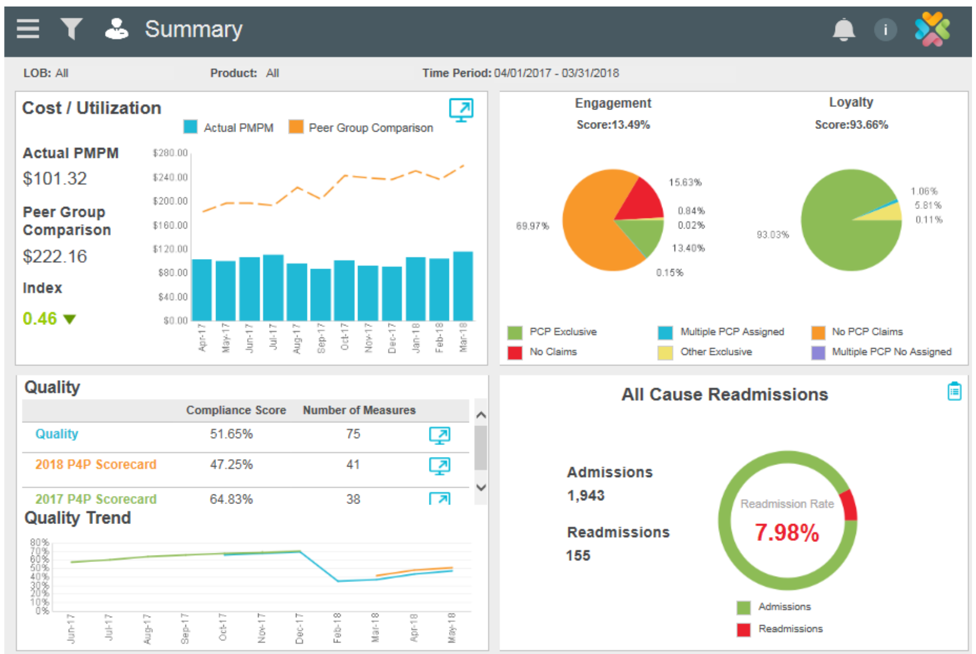
2A	Visit nhhealthyfamilies.com > Provider Resources > Manual Forms & Resources and download the Provider Change Form.
2B	Complete the form and email to: MA-NH-Terms@CENTENE.COM Note: When terminating a PCP please supply another PCP to move their members to.

Provider Engagement Tools

Provider Analytics Tool

Your Pay-for-Performance, Cost and Utilization Reporting Tool

The updated Provider Analytics solution now includes peer group risk-adjusted cost and utilization data



Sample view of the enhanced Provider Analytics landing page

- **Summary page** with graphical view of PMPM cost and utilization data
- **Patient engagement** analysis to understand patient preferences and utilization of primary care services**,** based on claims history
- **Emergency Department reporting** including patients seen in the past 90 days, top unmanaged conditions, disease states, and total visits
- **Member-level drill down and export** for insights into outreach opportunities
- **Refreshed monthly** to ensure current and actionable data

Log in today and explore Provider Analytics to discover how it can benefit your practice! Contact your Provider Network Specialist with questions.

Patient Analytics Tool

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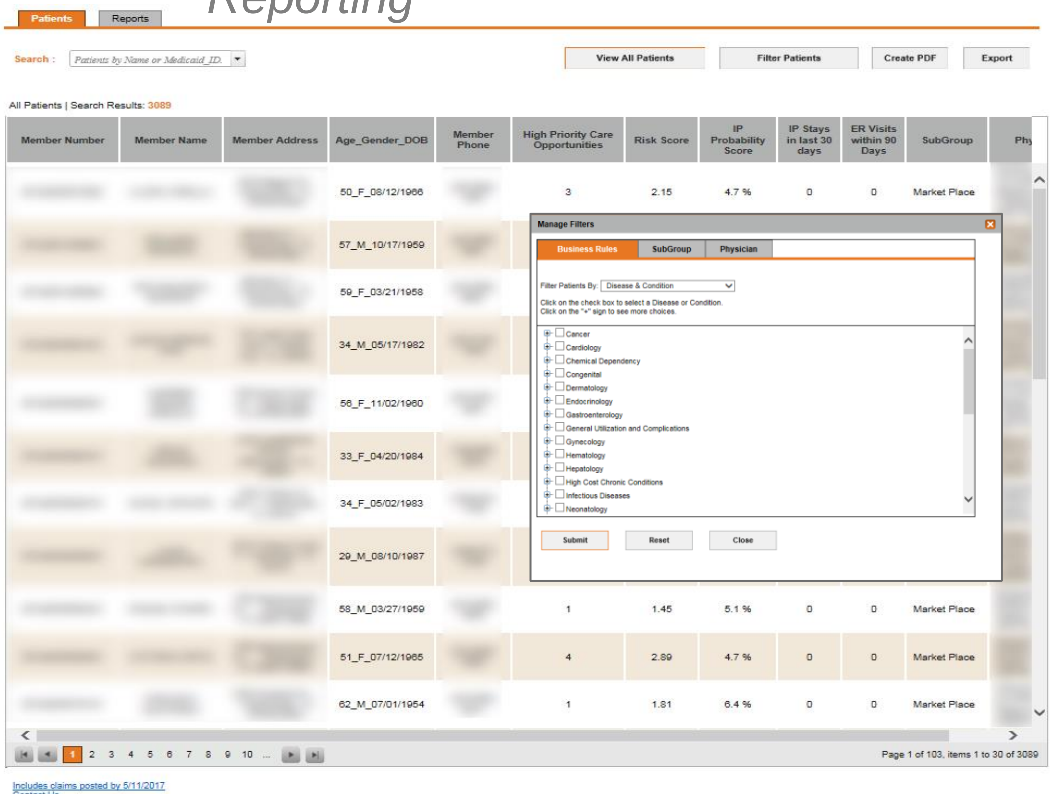
Your Web-Based Patient Care Platform That Uses Claims Data to Create Detailed Patient- and Population-Level Reporting



- **Tabs:** Allows the providers to choose between the Patients information and Reports.
- **Logout Button:** For security purposes, logout to protect patient information. Not shown, in upper right hand corner.
- **Search:** Allows providers to search by the patient's name, Medicaid, Medicare or Marketplace ID number.
- **Filters and Export Features:** Allows users to view all patients or filter by multiple criteria. The users will also have the ability to create a PDF document or export a detailed patient profile.

  Manage Filters: Filter the patient list by business rules, subgroups, and physicians.
- **Timeframe:** Provides the date when claims have been posted, followed by a link to contact for questions or concerns.

Patient Analytics Tool,(con't.)

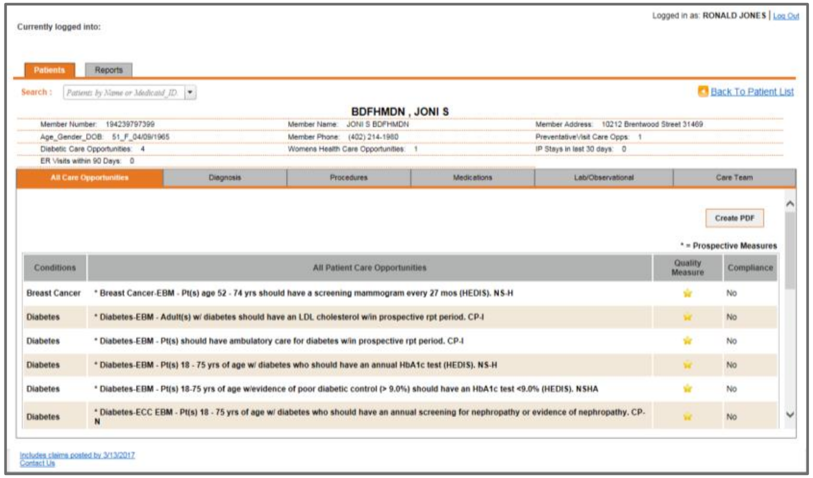
Search Results

All Patients | Search Results: 3089

Member Number	Member Name	Member Address	Age_Gender_DOB	Member Phone	Hig O

- **High Priority Care Opportunities:** Displays a count of care opportunities deemed to be of the highest importance.
- **Risk Score:** Identifies the likelihood that the patient will incur cost and services in the next 12 months when compared to an average patient. An average patient has a health of 1.0. Higher values indicate the patient is more likely to need services in the future.
- **IP Probability:** A percentage indicating the likelihood that a patient will have one or more inpatient confinements in the next 12 months.
- **Inpatient Stays in the Last 30 Days:** A metric that captures the number of distinct inpatient hospitalizations in the last 30 days based on processed claims.
- **Emergency Room Visits within 90 Days**: A metric that shows the number of distinct emergency room visits within 90 days based on processed claims.
- **Subgroup**: Medicaid, Medicare, or Marketplace.
- **Physician:** Displays the provider's name and credentials.

Patient Profile



- **Member Demographics:** Displays information about the member.
- **All Care Opportunities:** *The default landing page for patient details.* Displays care opportunities or measures that indicate if a patient has or has not received treatment for a health condition.
- **Diagnosis:** Shows primary and secondary diagnoses from claims data.
- **Procedures:** Shows patient procedures associated with primary and secondary diagnoses.
- **Medications:** Displays a list of medications prescribed to the patient.
- **Lab/Observational:** Shows lab values, interpretations, and trends.
- **Care Team:** Allows users to view the patient's providers. Providers are labeled as Managing Doctor or Other Doctor.

Provider/Patient Tools Comparison

PROVIDER Analytics Online Tool	PATIENT Analytics Online Tool
Summary page with graphical view of PMPM cost and utilization data	**Tabs:** Allows the providers to choose between the Patients information and Reports.
Patient engagement analysis to understand patient preferences and utilization of primary care services**,** based on claims history	**Logout Button:** For security purposes, logout to protect patient information. Not shown, in upper right hand corner.
Emergency Department reporting including patients seen in the past 90 days, top unmanaged conditions, disease states, and total visits	**Search:** Allows providers to search by the patient's name, Medicaid, Medicare or Marketplace ID number.
Member-level drill down and export for insights into outreach opportunities	**Filters and Export Features:** Allows users to view all patients or filter by multiple criteria. The users will also have the ability to create a PDF document or export a detailed patient profile.
Refreshed monthly to ensure current and actionable data	**Timeframe:** Provides the date when claims have been posted, followed by a link to contact for questions or concerns.

Risk Adjustment

Risk Adjustment / Provider Responsibilities

Providers play a significant role in Risk Adjustment from accurately coding, to submitting claims and complying with audits. The success of a Risk Adjustment program relies on provider offices to:

- Accurately assess member's health status to include chronic and complex conditions
- Address any suspected chronic conditions listed on the health form provided by health plan
- Document confirmed conditions, assessments, and medical notes appropriately in the member's medical record
- Ensure diagnoses are coded using applicable ICD-10 code to address medical conditions
- Ensure codes are accurate by coding to the highest-specificity when applicable (using correct CPT/HCPS codes to support visit)
- Order and/or complete preventive measures to close HEDIS gaps
- Use appropriate procedure codes applicable for visit
    - G0438-Initial visit
    - G0439-subsequent visit
    - 99381- 99397-preventive services visits
    - 99201-99215-problem focused visits (acute or chronic)
- Ensure patient's entire risk profile is accurately reflected in the medical record and coded properly in claims and encounter data

Risk Adjustment / M.E.A.T

Providers must take advantage of every face-to-face visit with their patients to provide adequate/holistic care. Providers should use the acronym **M.E.A.T** to establish the presence of a condition during an encounter.

M.E.A.T. helps to identify the clinical significance of a diagnosis which helps properly assign the appropriate ICD-10-CM code for that condition. M.E.A.T. ensures that documentation meets CMS/ state requirements for supporting and validating risk adjustment diagnoses

M.E.A.T stands for:

M – Monitor signs, symptoms, disease progression or regression
E – Evaluate test results, medication effectiveness, and response to treatment
A – Assess/address by testing, discussing, reviewing records, and counseling
T – Treat with medications, therapies, other modes

Risk Adjustment / Coding

Providers must also ensure coding and documentation of conditions and diagnoses are accurate and adequate.

Coding Tips:

- Submitted codes must be supported by documentation in the medical record that provides evidence of the problem/condition being addressed
- Note must be dated and signed in the patient record
- Electronic health record (EHR) must be electronically signed
- Condition must be identified and coded to the highest specificity that exists, and must include a brief assessment and plan. Listing condition without further elaboration is not sufficient. It must be supported in the history, exam, and/or plan
- Specify if condition is chronic
- Document chronic conditions annually
- Only conditions evaluated during the face-to-face encounter should be documented and coded
- Understand proper use of "history of"; this is acceptable if it affects current treatment plan
- Code diagnosis to the highest specificity for present conditions

It is important for providers to understand the capacity of their Electronic Medical Record (EMR) system and the number of codes the system is able to submit. Many codes are lost because EMR systems do not have the bandwidth to hold them.

Risk Adjustment / Benefits

Effectively managing the risk of members is beneficial for the member, provider and the health plan.

Benefits Include:

- Improving quality of care for members
- Better coordination of care between payer, health plan and member
- Improved care leads to improved member health outcomes
- Allows payers to offer more comprehensive and affordable benefit packages to member

Network Adequacy

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A key responsibility of the Provider Relations Specialist is to monitor network adequacy on a continual basis in order to ensure NH Healthy Families continues to have a robust network that meets the needs of members and providers. Your dedicated Provider Relations Specialist will keep you and your staff apprised of any network changes, new additions or needs within the geographic area you serve, and may - from time to time - survey you regarding your referral network and any preferences you may have with regard to certain providers to target for participation in the NH Healthy Families' provider network.

- Are you able to find the right healthcare providers for your patients?
- What are the challenges that your patients face when trying to access care?
- Are there providers in your area that we are not contracted with that you would suggest we reach out to?

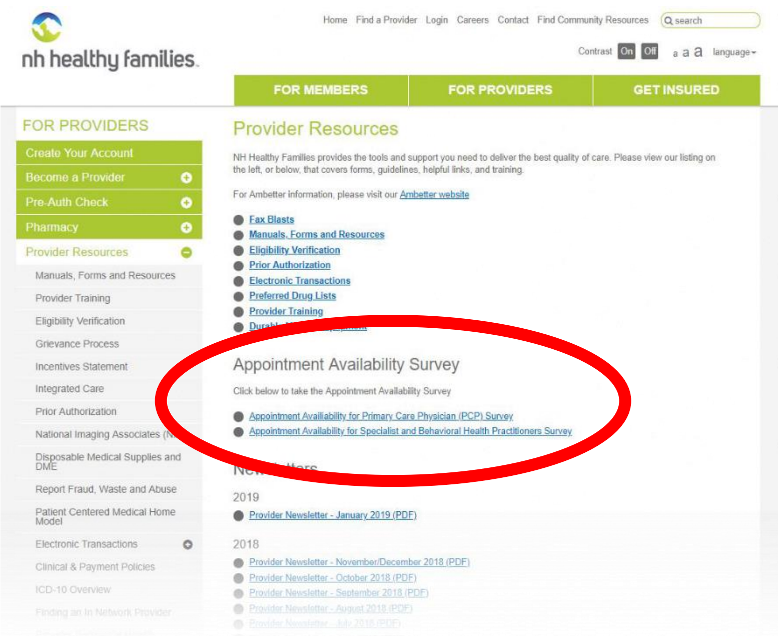
Appointment Availability Standards Survey

In an effort to assess the current availability of primary care, specialist and behavioral health services to our members, we have developed a short survey to monitor and evaluate member access to services. We appreciate your commitment to meeting the New Hampshire State Standards for Access and Availability.

Please take a few minutes to complete the electronic survey by visiting:

NHhealthyfamilies.com – For Providers – Provider Resources.

Click on the applicable survey (Specialist/Behavioral Health or PCP) under the Appointment Availability Survey header.



Quality Improvement Updates

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- Promote scheduling educational presentations (if a PCP office) such as EPSDT overview, Care Management 101, Quality/HEDIS meeting.
- Quality Improvement Monthly Educational Topics (review monthly updates/topics with provider)

Notification of Pregnancy

- **Notification Of Pregnancy (NOP) Incentive Program** rewards participating OB/GYNs, midwives and PCPs for completing and submitting NOP forms in a timely manner. NOP forms help NH Healthy Families identify pregnant members who may have a history of preterm delivery, psychosocial issues or other conditions that may complicate the course of their pregnancy.

- Provider offices will be reimbursed for the completion and submission of NOP forms. The incentive is payable for pregnant members initially identified by the provider office. This means any member identified prior to your submission of the form from another source would not be eligible for the incentive program.

Provider Group Incentive Rewards:

- **$25** for each form submitted during the first and second month of pregnancy.
- **$20** for each form submitted during the third and fourth month of pregnancy.
- **$15** for each form submitted during the fifth and sixth month of pregnancy.

Prenatal Vitamins

- NH Healthy Families members are eligible for a 3 month supply of prenatal vitamins at no cost
- Providers can fill out our Prenatal Vitamin Ordering Form and fax it to us
- Prenatal vitamins can be shipped directly to the member or the provider's office
- The Prenatal Vitamin Ordering Form can be found on our website under "Provider Resources"

Questions

- Questions?
- Comments?
- Suggestions?

Thank you!