CARE1ST PROVIDER FORUM

AGENDA

- Care1st Overview
- Network Management updates
- Care1st Resources
- Medical Claims
- Medical Prior Authorization
- Behavioral Health
- Member Advocacy
- Pharmacy Updates
- Quality Improvement
- Dental Resources, Updates and Claims
- Dental Prior Authorization and Tips

Care1st Overview

Care1st Provider Satisfaction

- Provider Satisfaction:
  - Care1st's goal is to ensure all your interactions with the health plan are helpful and productive

  How to accomplish this goal:
  - Actively seeking your feedback
  - Claims processing accuracy
  - Quality and meaningful customer service
  - Robust provider services and network
  - Accurate and timely responses to prior authorization requests
  - Meeting *your* specific needs

Care1st Overview

- In January 2017 WellCare became Care1st's parent organization
  - WellCare focuses exclusively on providing government sponsored managed care services
  - The priority is to ensure that we provide timely and quality service
- October 2018 Care1st awarded Central and North GSA
- January 2019 Care1st rebranded the ONECare (D-SNP) program to WellCare Liberty
- January 2019 WellCare introduced WellCare Value in Maricopa and Pima County
- March 2019 Centene's proposed acquisition of WellCare*

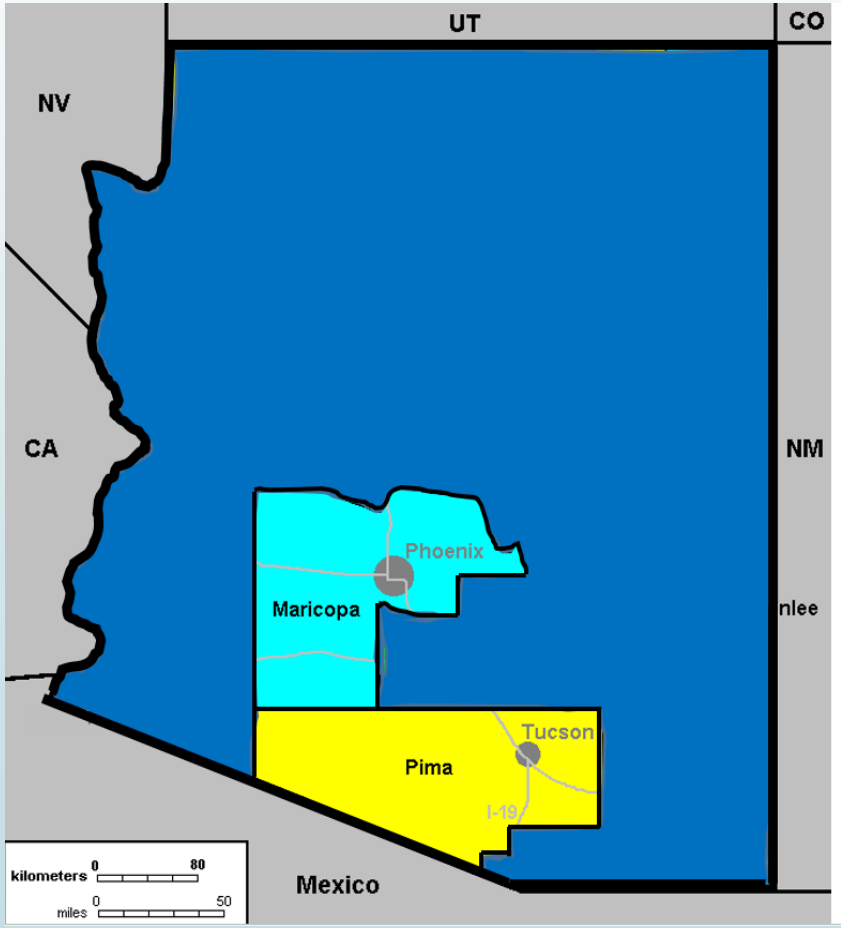
*Centene's proposed acquisition of WellCare

Here is what we know:

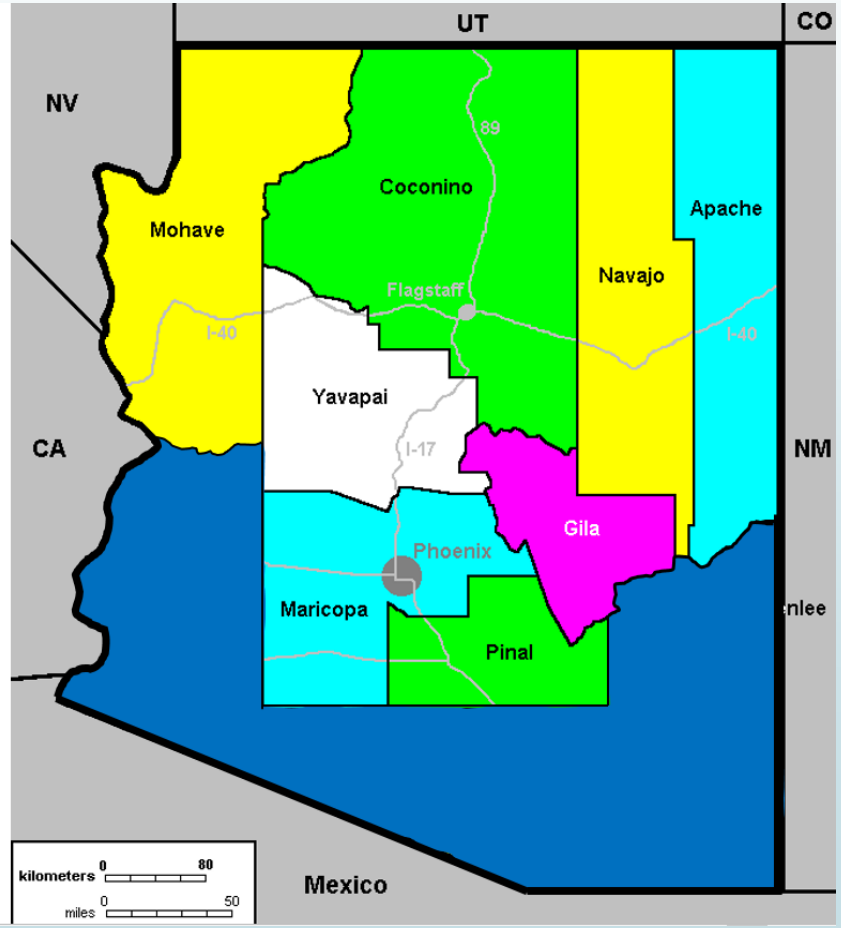
- Migration is delayed: Care1st/WellCare will maintain as is currently until we can ensure a smooth transition for our provider community
- WellCare Liberty: status quo, Liberty is maintaining its programs and tools available via the WellCare Provider Portal
- Care1st: status quo, Care1st is maintaining its programs and tools via the Care1st Provider Portal
- As of right now it's business as usual. This is still a *proposed acquisition* and currently in the regulatory review process. Your provider representative will keep you up to date with any developments

Care1st Overview

- Previous Geographical Service Areas



- Geographical Service Areas effective 10/1/18



Care1st Overview

AHCCCS Complete Care Membership Overview effective April 2019

- Maricopa – 110,310
- Gila - 80
- Pinal - 356
- Yavapai – 29,890
- Mohave – 17,814
- Coconino – 8,572
- Navajo – 7,119
- Apache – 2,190

Care1st Overview

Network Management Updates

- Network Management Representatives
  - Maricopa
    - Northwest Valley – Alethea Ortega alethea.ortega@wellcare.com
    - Northeast Valley – Deborah Discont deborah.discont@wellcare.com
    - South Valley – John Schneider john.schneider@wellcare.com
    - Central Valley – Gail Garrison gail.garrison@wellcare.com
    - Southeast Valley – Steve Bigman steve.bigman@wellcare.com
    - Southwest Valley – Ivette Gastelum ivette.gastelum@wellcare.com
- Additional Support Staff across the organization to accommodate the expansion

Care1st Overview

Network Management Updates

- Network Management Representatives
  - The following counties have a Network Management Rep assigned
    - Mohave/Apache – Diana Dunlap diana.Dunlap@wellcare.com
    - Coconino/Navajo – Sherri Smith sherri.smith@wellcare.com
    - Yavapai – Dale Wilson dale.Wilson@wellcare.com
    - Gila/Pinal – Daniel de la Vara daniel.delavara@wellcare.com
    - Pima – Lorita Smith lorita.smith@wellcare.com
  - We are also adding additional staff to assist with increased phone calls, provider adds, changes and terms

Find the territory assignment grid here:
https://www.care1staz.com/az/pdf/provider/ProviderTerritoryGrid_0219.pdf?ver=02.19

Care1st Resources

Changes to your practice

- Please communicate any changes to your practice to ensure accurate processing of claims, payment and directory information
- Includes providers joining or exiting, address changes, fax or phone numbers, etc.
- Please send notification by fax 602-778-1875 or by email SM_AZ_PNO@Care1staz.com.
- You may also contact your Network Management Rep directly
- Any provider additions need to be accompanied by a completed AzAHP form

Care1st Resources

Provider Loading Process

- A request (AzAHP Practitioner Data Form) is received by the Network Management Team to add a provider to your group
  - Reminder – all elements must be completed
  - Newest form is available on our website
- That request is added to the Network Management database and forwarded to credentialing
- Credentialing cannot begin unless the CAQH application is updated and complete
- When credentialing is completed, the provider is loaded into our claims payment system and
- A welcome letter is sent notifying the practice of the effective date

Home Arizona

Provider Login | ONECare

CARE1ST HEALTH PLAN ARIZONA
A WellCare Company

Select Language

Welcome Providers

We're transitioning to WellCare Health Plans! In October 2016, the company behind Care1st and ONECare was acquired by WellCare Health Plans, Inc. You play a very important role in the delivery of health care services to our members. We are committed to working closely with you. We continually strive to remove administrative barriers, so that you can focus on caring for our members.

Medical administration including: Member Services, Prior Authorization, Claims, Provider Network Operations, Case Management, Disease Management, Concurrent Review, Quality Management and Behavioral Health are housed in the same central location in Phoenix, fostering close communication and coordination between all areas.

Care1st Home

For Providers

- Blast Faxes
- Compliance Resources
- Community Resources
- Dental
- Disease Management
- E-Prescribing
- Filing a Claim
- Forms
- Formulary
- Forums
- ICD-10
- Login
- Mailings & Reference Materials
- Manual
- Our Network
- Practice & Preventive Health Guidelines
- Prior Authorization Guidelines &

Care1st Health Plan Arizona, Inc. is working with the community in which we service to provide you with high quality health care. We are working with a wide array of agencies, community based organizations, and local associations to collaborate on events to inform the public about the health care, health care choices available, and health education.

- General Resource and Referral +
- Children's Health and Wellness +
- Individuals with Developmental Disabilities +
- Individuals with Autism Spectrum Disorder (ASD) +
- Autism Spectrum Disorder Providers +
- Peer and Family Support +
- Low Cost Dental Services +
- Veterans and Military Families +
- Tribal Members +

Mailings & Reference Materials

Care1st and ONECare produces network mailings and reference materials for our provider network. The network mailings are designed to provide updates, helpful reminders and tools. Updated forms, copies of recent blast fax communications and our Quick Reference Guide (specifically designed to be a useful reference tool for you and your staff) are included.

Below is the most recent Network Mailing and Reference Materials.

Mailings

- Provider Network Mailing PDF
- Quick Reference Guide - Effective 01/01/2019 PDF
- Quick Reference Guide - Effective 09/01/2018 PDF

Reference Materials

News you can use!

- Billers' Corner - Reduce Denials on Paid Claim Submissions PDF (September 2018)
- Billers' Corner - Modifier Clarification PDF (April 2018)
- Billers' Corner - Outpatient Occupational, Physical, & Speech Therapy PDF (February 2018)

Forms

Prior Authorization

- Pharmacy Prior Authorization Request
- Medical/Behavioral Health Prior Authorization Form
- Sterilization Consent
- Authorization/ Pregnancy Risk Assessment
- RSV Prophylaxis Eligibility Assessment

Case Management / Behavioral Health

- Care1st Case Management Referral Form
- MMIC Referral for Behavioral Health Services Form
- CIC Referral for Behavioral Health Services Form - Pima County

Credentialing & Contracting

- AzAHP Practitioner Data Form
- AzAHP Organizational Data Form
- AzAHP Facility Application

Other

- Claim Dispute
- Electronic Funds Transfer Authorization Form (ETF)

- Login
- Mailings & Reference Materials
- Manual
- Our Network
- Practice & Preventive Health Guidelines
- Prior Authorization Guidelines & Criteria
- Provider Rep Contact Info
- Quality Measure Results

Provider Manual

Click on the appropriate section title below to view and/or print the contents of a particular section or view the entire manual PDF

TABLE OF CONTENTS:

Provider Manual Sections

Provider Blast Faxes

2019

- **04/04/2019** - UPDATES TO PRIOR AUTHORIZATION GUIDELINES EFFECTIVE MAY 1, 2019
- **04/01/2019** - SPECIALTY PHARMACY NETWORK FOR CARE1ST AHCCCS EFFECTIVE 4/1/2019
- **03/29/2019** - CLAIM SUBMISSION, SNIP EDITS, CORRESPONDENCE, REAL-TIME AND EFT UPDATES NEW EFFECTIVE DATE 6/1/2019
- **03/29/2019** - CHANGES TO EFT/835/ELECTRONIC REMITTANCE ADVICES
- **03/20/2019** - DENTAL CLINICAL AND BILLING GUIDELINES UPDATE
- **03/15/2019** - CARE1ST MEDICAID PLAN CHANGES NEW EFFECTIVE DATE 6/1/2019
- **03/14/2019** - PUBLIC HEALTH AGENCIES ANNOUNCE CONFIRMED MEASLES CASE IN PIMA COUNTY
- **03/12/2019** - ADDRESSING THE INCREASE OF SYPHILIS IN ARIZONA

Care1st Home

For Providers

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- Provider Rep Contact Info
- Quality Measure Results

Care1st Health Plan Arizona

We're transitioning to WellCare Health Plans! in

October 2016, the company behind Care1st and ONECare was acquired by WellCare Health Plans Inc. As a result, we will be transitioning to a new Provider Portal beginning with 2019 ONECare plans.

Provider Login

Username

Username

Password

Password

Passwords are case sensitive

TERMS OF USE ; DISCLAIMER

☐ I have read and understood the Terms of Use

Login Reset

Not registered? Click here to Request Access.

Welcome Providers!

Welcome to the Provider Area, where you can access Member Eligibility, Status Claims, search for Providers, view and print Remittance Advices and more.

Please select an area from your choices below:

MEMBERS

CLAIMS

PROVIDERS

REMITTANCE

Claims Search

Instructions | By Member Number | By Claim Number | By Authorization Number | List Claims

Instructions

There are four search methods to locate a claim:

1. **Search Claims by Member Number**
   Member Number Formats:
   - AHCCCS and DDD Members = Axxxxxxxx
   - Health Care Group Members = H000xxxxxx
   - ONECare Members = xxxxx*01
2. **Search by Claim Number**
   - Enter Claim Number and Search
3. **Search by Authorization Number**
   - Enter Authorization Number and Search
4. **List Claims for the Past**
   - Enter the number of days for which you wish to display claims

Medical Claims

Medical Claims

Top 5 Claim Denials last month

1. Exact Duplicate – 9,051
2. Primary Insurance on file – 7,660
3. Patient not eligible on date of service – 3,417
4. Provider not contracted –2,205
5. Timely Filing Denials – 1089

Sonora Quest is Care1st's exclusive provider of laboratory services

- Top provider specialties by volume with out-of-network lab referrals
  - Urgent Cares
  - Pain Management
  - OB GYN

Medical Claims

- Outreach, Partnership and Resources
  - Weekly high volume denial report
  - Denial trend reports (JOC, high volume, or by request from AZClaimsLiaisons@Care1stAZ.com)
  - Customer service and audit trending
  - Billing and Utilization Workgroups
- Upcoming Changes to remits and EDI rejection letters
  - Branding changes to remits adding WellCare logos and address
  - Minor wording differences to remit detail (Comparison on next slide)
  - Increase in rejections on 837 file submissions in lieu of claim denials
    - NPI errors/omissions
    - Invalid CPT/HCPC codes
    - Invalid Diagnosis codes
    - Eligibility

Medical Claims

CARE1ST HEALTH PLAN AZ, INC.
P.O. BOX 31370
TAMPA, FL 33631

WellCare
Beyond Healthcare. A Better You.

PLEASE REVIEW LAST PAGE OF THIS DOCUMENT FOR FURTHER DESCRIPTION OF EXPLANATION CODES

Questions regarding your Explanation of Payment should be directed to Claims Customer Service 866-560-4042

Remittance Advice

Payee: [redacted]	Check Date:	3/8/2019	Tax ID: [redacted]	NPI#: [redacted]	
Check Number [redacted]	Check Amount:	$140.60	Vendor: [redacted]	LOB:	AMD - MEDICAID

Dates of Service	Billed Procedure/Modifier	Paid Procedure/Modifier	Billed Units	Paid Units	Denied Units	Billed	Allowed	Co-Pay Amount	Co-Ins Amount	Deductible Amount	Other Carrier	Discount	Paid	Explanation Code
Provider [redacted]		NPI#: [redacted]		Provider ID#: [redacted]			Patient ID#: [redacted]			DRG Code:			Total PR: 0.00	
Member [redacted]		Clm#: 787010111			Interest: 0.25		Add-on: 0.00			Pt Acct: [redacted]			Clm Lvl PR: 0.00	
12/14/2018 -	97110 GP THERAPEUTIC PROCED	97110 GP THERAPEUTIC PROCED	1	1	0	65.00	27.14	0.00	0.00	0.00	0.00	0.00	27.14	PCFSC
						65.00	27.14	0.00	0.00	0.00	0.00	0.00	27.14	

TIN: [redacted]

Document No: [redacted]	Member: [redacted]	State ID #: [redacted]		Patient ID: [redacted]		Claim Provider: [redacted]	
DRG:	Date Approved: 03-15-18	POS:	11	Health Plan ID:		Payment To:	VENDOR $130.00

Dates of Service (From - Thru)	Procedure Code	Procedure Description	Qty	Req Amt	Elig Amt	COB Amt	Disc	Co-pay	Coins	Ded Amt	Pay Amt	Adj Code
03/05/18-03/05/18	97110GP	THERAPEUTIC EX	1	65.00	65.00	0.00	0.00	0.00	0.00	0.00	65.00	CFEE
03/05/18-03/05/18	97140GP	MANUAL THERAP	1	65.00	65.00	0.00	0.00	0.00	0.00	0.00	65.00	CFEE
03/05/18-03/05/18	97530GP	THERAPEUTIC AC	1	55.00	30.80	0.00	0.00	0.00	0.00	0.00	0.00	ICR
		Claim Totals		185.00	160.80	0.00	0.00	0.00	0.00	0.00	130.00	

Medical Claims

Documenting the Prior Authorization number on claims

- CMS1500 – Services requiring authorization must have the authorization number populated in field 23 (EDI Loop 2300)
- UB04 - Services requiring authorization must have the authorization number populated in field 63 (EDI Loop 2300)

Resubmissions and void requirements

- Resubmissions on CMS1500 forms must include indicator 7 and the original claim number in field 22 (EDI Loop 2300)
- Voided claims on CMS1500 forms must include indicator 8 and the original claim number in field 22 (EDI Loop 2300)
- For UB04 forms bill type XX7 (replacement) or XX8 (void) with the original claim number in field 64 (Loop 2300)

Medical Claims

Mailing address and EDI Payer ID

- No change to the Care1st payer ID for electronic claims 57116
- Mailing address for paper claims

WellCare Health Plans
Claims Department
PO Box 31224
Tampa, FL 33631-3224

- Billing correct member ID Medicare and Medicaid and date of birth
  - When both WellCare Medicare and Medicaid coverage exist bill the Medicare ID first
  - Wellcare Liberty claims are crossed over internally secondary submission is not required
- Reminder: Faxed or black and white claims are not accepted and will be rejected

Claims Web Resources (See Links)

- QRG: https://www.care1staz.com/az/pdf/provider/mailings_and_materials/2019/QuickReferenceGuide_Winter2019.pdf?ver=3
- Prior authorization tool: https://www.care1staz.com/az/PDF/provider/PriorAuthReferenceGrid/2019/PA0119.pdf

Medical Claims

Total OB Billing

- Effective for service dates 6/1/19 and after authorization will no longer be required for Total OB Services. *Notification is still required within 30-days of initial visit.
- In order to eliminate claim recoupments when a claim qualifies for Total OB Care Package reimbursement (5 or more prenatal visits) with delivery, antepartum services should be billed as indicated below. If billing dates of service for antepartum care prior to delivery bill each visit on an individual line with the date visit and a line charge of either 0.00 or 0.01.
  - These services can be billed as they occur, or on single claim after all visits have been incurred
  - Visits during the TOB care period for a non maternity related diagnosis be billed as fee for service
- Billing Example
  - **Delivery Claim**

    Line 1: The appropriate OB care delivery CPT code
  - **Claim for Antepartum visits**

    Line 1: 1st antepartum visit billed with date of service and E&M CPT code (with $.00 or $.01 billed charges)

    Line 2: 2nd antepartum visit billed with date of service and E&M CPT code (with $.00 or $.01 billed charges)

    Line 3: 3rd antepartum visit billed with date of service and E&M CPT code (with $.00 or $.01 billed charges)

    Line 4: 4th antepartum visit billed with date of service and E&M CPT code (with $.00 or $.01 billed charges)

    Line 5: 5th antepartum visit billed with date of service and E&M CPT code (with $.00 or $.01 billed charges)

    Line 6: 6th antepartum visit billed with date of service and E&M CPT code (with $.00 or $.01 billed charges)

Medical Claims

Included in TOB	
Antepartum Visits - 5 or more	Artificial Rupture of Membranes
Postpartum Visit - 1 (*Includes pap smear) w/in 60 days of delivery	Breast Stimulation Studies
EPSDT visits Exception: Allowed separately if primary DX is not pregnancy related	External Cephalic Versions
Family Planning	Fetal Scalp Monitoring
Inpatient & Observation Services (*Including visits) *Exception: Allowed separately if primary DX is not pregnancy related	Genetic Counseling (*Excludes Testing billed by different vendor)
Physical Exams* *Exception: Allowed separately if primary DX is not pregnancy related	Maternity Counseling
Initial & Subsequent History Exception: Allowed separately if primary DX is not pregnancy related	Nutritional Evaluations
Lab Services & Handling billed by TOB provider Exception: Allowed separately if primary DX is not pregnancy related	Prostaglandin Gel Insertion
Induction of Labor	Wet Preps & Wet Mounts
Delivery (*Including Multiple Births)	Weight & Blood Pressure

Medical Claims

Excluded from TOB	
RhoGAM Injections	Amniocentesis
ALL OB Ultrasounds (*3D ultrasound requires authorization)	Assistant Surgeon for C-Section Delivery
Amnioinfusion (*Requires authorization)	Lab Services not billed by TOB provider
Postpartum Tubal Ligation	Non-Stress Test (authorization is required when performed by Perinatologist)
Flu Vaccine/routine vaccine	Colposcopy
EPSDT - When primary DX code is not pregnancy related	Physical Exams (Including sick exams) - When primary DX code is not pregnancy related
Inpatient & Observation Services - When primary DX code is not pregnancy related	Initial & Subsequent History - When primary DX code is not pregnancy related
Lab Services & Handling billed by TOB provider – When primary DX code is not pregnancy related	Sterilization
Post Delivery D & C (59160)	Lesion destruction (56501)
Administration fee for J1726 if member obtains injectable from the pharmacy and takes it to the provider's office for administration	Administration fee for J1729 if member obtains the injectable from the pharmacy and takes it to the providers office for administration

Prior Authorization and Updates

Medical Prior Authorizations

- Medicaid Prior Authorization Grid – Please use as a resource
  - Last updated January 2019
- Liberty Prior authorization look-up tool is
  - https://www.wellcare.com/en/Arizona/Providers/Authorization-Lookup
- Liberty fax number: 866-246-9832
- WellCare Customer Service: 1-800-351-8777
- Care1st Customer Service: 602-778-1800
- Care1st fax number: 602-778-1838

Pharmacy Updates

- Old TAT for Standard Requests
  - 14 business days with the ability to extend for 14 additional days if information is needed. Total of 28 days
- Old TAT for EXPEDITED Requests
  - 3 business days with the ability to extend for 14 additional days if information is needed. Total of 17 days
- NEW TAT
  - 24 hours regardless of Expedited or Standard designation
  - Expedited requests can be held for 72 hours to obtain information
  - Standard requests can be held for 7 days to obtain information
  - Request for information must be made within 24 hours of receipt

Urgent Requests

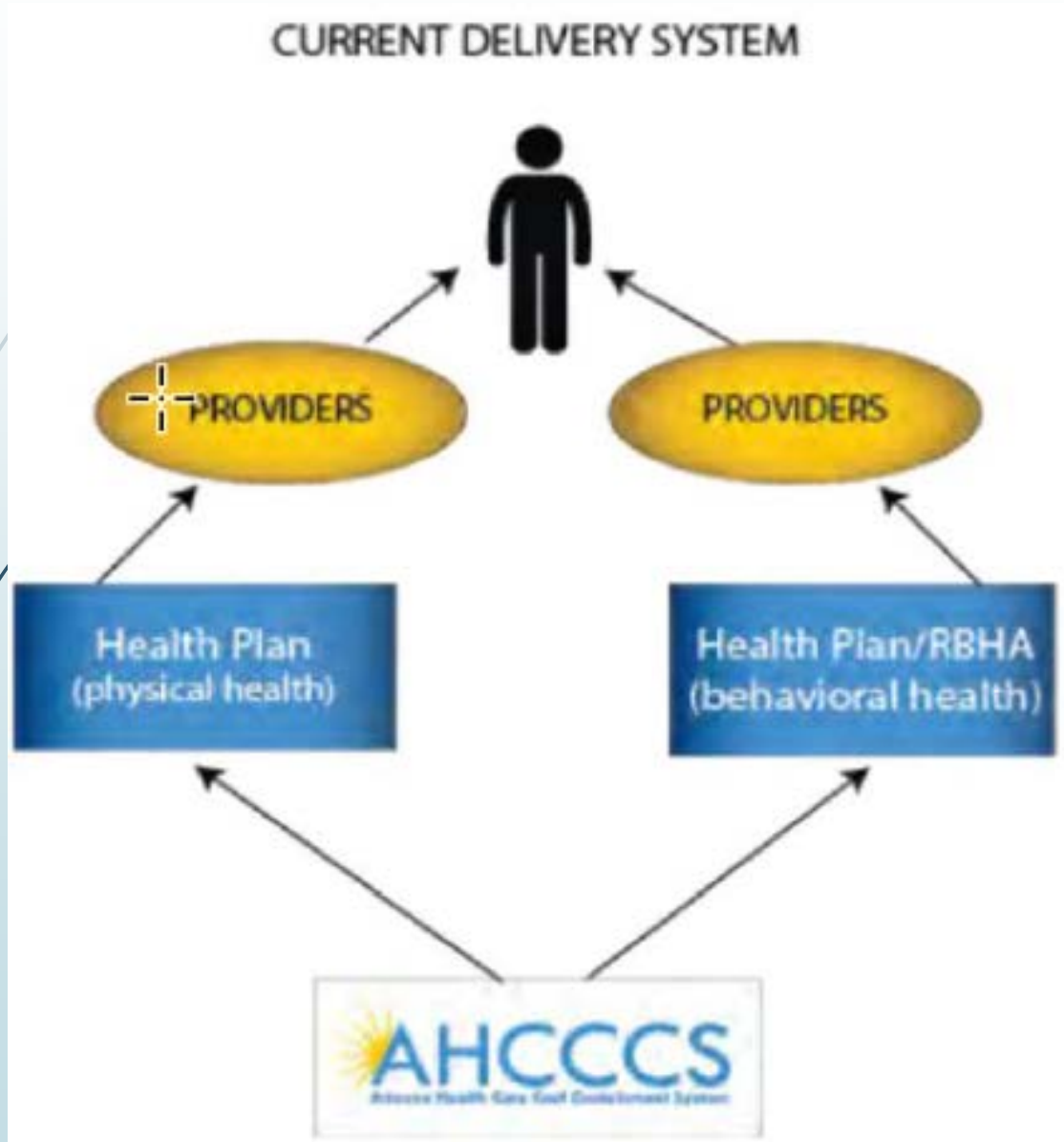
AHCCCS defines an URGENT request as follows:

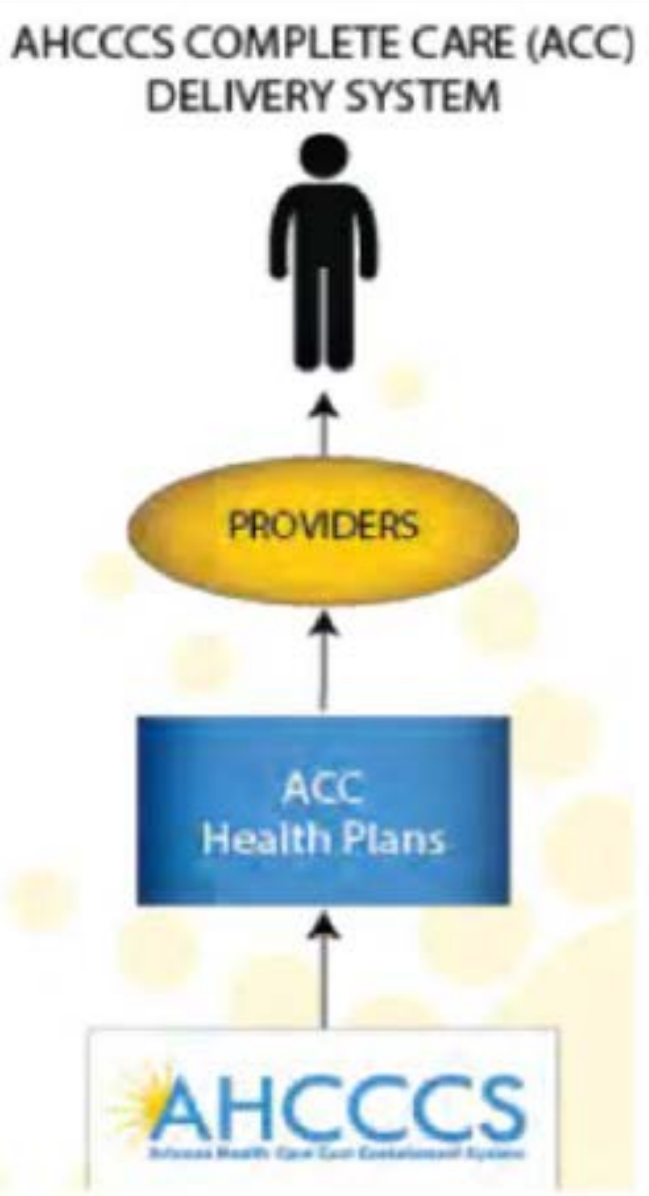
"A request for services in which either the requesting provider indicates or the contractor determines that following the standard timeframes for issuing an authorization decision could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function".

- By marking a request urgent when it does not meet the above definition, we may have less time to obtain necessary information
- A request submitted as urgent could be downgraded by clinical staff to a standard/routine request. If the provider can show the request meets the urgent definition, above, the provider can call and speak with the clinician that downgraded the initial request.
- Appointment availability or scheduled services, do not meet the urgent definition

Behavioral Health

October 1 2018 Changes in Service Delivery





Behavioral Health Service Delivery

- Delivered in accordance to Arizona's Vision
  - Easy access to care
  - Behavioral health recipient and family member involvement
  - Collaboration with the greater community
  - Effective innovation
  - Expectation for improvement
  - Cultural Competency
- Twelve Principles for the Delivery of Services to Children
- Nine Guiding Principles for the Delivery of Services to Adults

BH Provider Network

- MD/DO Psychiatrist (*adult and child*)
- Psychiatric Nurse Practitioner
- Psychologist (*Ph.D. and Psy.D*)
- Licensed Clinical Social Worker (*LCSW*)
- Substance Abuse Treatment Providers (*including outpatient, inpatient, residential and detox) (LISAC,LASAC)*
- Inpatient Hospitals – acute, freestanding, state-operated
- FQHCs that have integrated behavioral health
- Peer and Family support (CSA)
- Outpatient Providers (PT-77) (BHP, BHT, CM)

BH Covered Services

- Assessment, Evaluation and Screening Services
- Counseling and Psychotherapy (individual, group, and family)
- Rehabilitation Services (skills development, employment support/ training)
- Medical Services
- Supportive Services (case management, peer/family support, unskilled respite, personal care services, etc.)
- Crisis Intervention Services
- Inpatient Services
- Residential Services
- Behavioral Health Day Programs

BH Screening and Referral

- PCPs screen adults for depression, anxiety, substance use/misuse, suicide risk annually
- PCPs use standardized screening tools e.g. ACES, PHQ-2, PHQ-9, CAGE, GAD-7
- Medical record reflects screening results and timely referral to BH provider if needed.
- PCP may initiate treatment within their scope of practice; must refer for behavioral therapy with MAT and coordinate care; some psychotropics will require PA.
- PCP must provide three culturally and linguistically appropriate BH provider referrals

PCP to BH Referral

- PCP can refer to an Outpatient Clinic Provider (PT 77) for specific services (i.e. peer support, counseling, etc.)
- Provider directory can be found at www.care1staz.com > Providers > Our Network
- Provider service line: 602-778-1800 or 1-866-560-4042 can assist with connecting to a par BH provider
- Care Coordination call line Monday-Friday 8am-5pm 602-778-8301
- PCPs can submit a referral to Care Management by using the *Care1st Care Management Referral Form* found here: https://care1staz.com/az/pdf/provider/Care1st_Case_Management_Referral_Form.pdf
- PCPs encouraged to establish collaborative relationships with neighboring BH providers

PCP Responsibilities to Behavioral Health

- Ongoing communication and coordination of care from both PCP and the BH Provider.
- Providing clinical information regarding member's health and medications to the treating provider, including behavioral health providers, within 10 business days of a request from the provider
- Maintaining the member's medical record, including documentation of all services provided to the member by the PCP, as well as any specialty or referral services including behavioral health
- Initiating referrals for medically necessary specialty care

FAQs

- Can a PCP refer or can a member self-refer for a behavioral health service?
  - Yes. Members and PCPs may obtain a list of contracted outpatient clinic providers on our website or by calling Care1st provider service line. An intake/assessment and treatment plan must be completed indicating the service(s) to be provided are medically necessary.
- Can a PCP refer or can a member refer directly to a Community Service Agency (CSA)?
  - Yes. The CSA must ensure that a member has a completed intake/assessment and treatment plan indicating the service(s) to be provided are medically necessary.
- What is Care1st's process for referring to a CSA?
  - Care1st is actively reviewing policy to determine the process for self or PCPs to refer directly to CSAs and will provide an update via blastfax, email, or provider forum when this is complete.

Key Contacts-System of Care

- Adult System of Care Administrator
  - Sandra Zebrowski, MD
  - Phone: 602-474-1317
  - Email: sandra.zebrowski@wellcare.com
- Children's System of Care Administrator
  - Vicki Cons, LCSW
  - Phone: 602-778-1834
  - Email: vcons@care1staz.com

Member Advocacy

Member Advocacy Department

Son Yong Pak
Director,
Member Advocacy

G'Kyshia Hughes
Senior
Member Advocate

Member Advocacy Council (MAC)

Purpose

- To provide guidance and communicate member, family and stakeholder feedback to Care1st leadership

Objectives

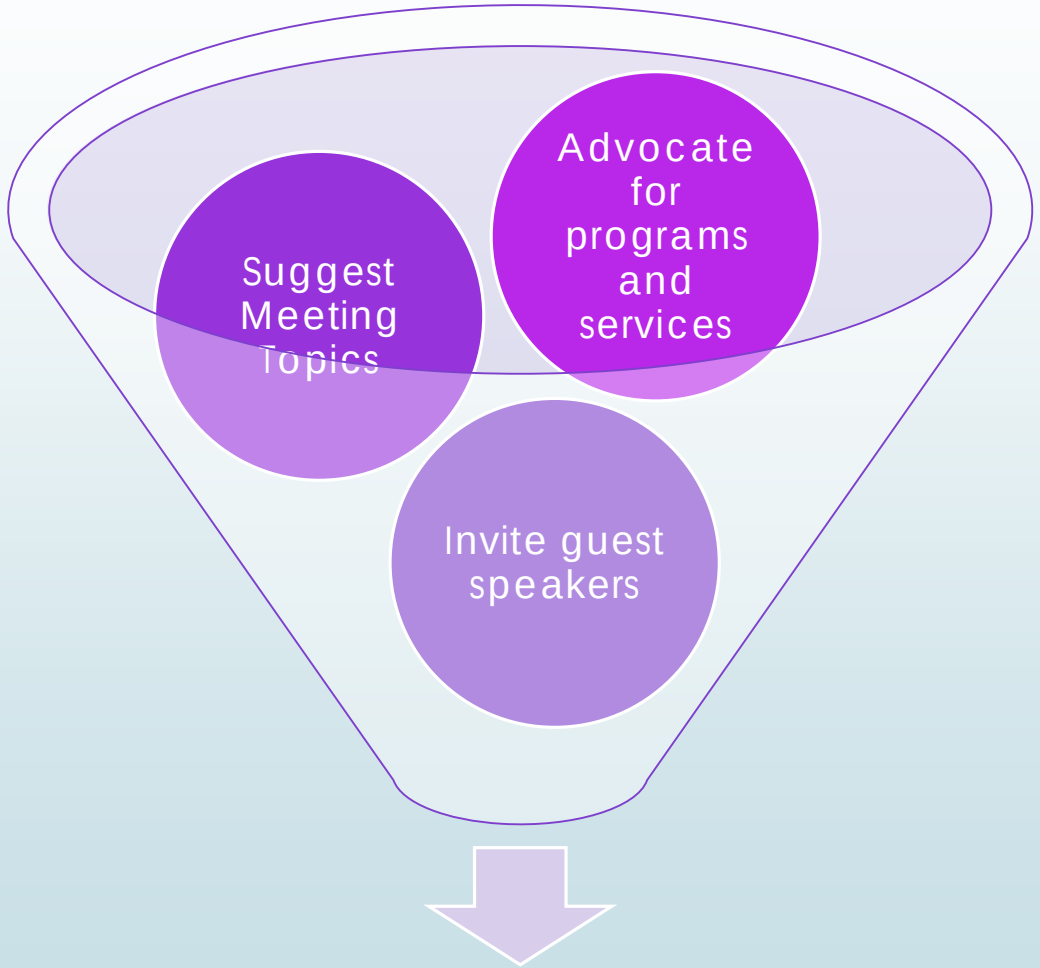
- Increase member and family voice
- Advocate for programs and services supportive of members and families
- Collaborate with members, families, and stakeholders to identify concerns and remove barriers that affect service delivery, service coordination and member satisfaction

Member Advocacy Council (MAC)

- Meeting frequency:
  - Quarterly in the central and northern regions.
- Year 1 membership target – open to all interested individuals:
  - Members receiving behavioral and physical health services.
  - Family members / caregivers.
  - Parent / guardian of a child who is or has been a child member with special health care needs.
  - Social service agencies.
  - Community stakeholders.
  - Advocacy groups.
- Year 2 - restructuring

Member Advocacy Council

Culture of Engagement



Identify concerns and remove barriers that affect service delivery, service coordination and member satisfaction

We Want to Hear From You!

- Share your ideas for presentations, discussion topics or ask a question

- Contact us at: mac_az@wellcare.com

Pharmacy Updates

Formulary Updates and PA Criteria

- AHCCCS next Pharmacy & Therapeutics Committee meeting is May 23rd & 24th with formulary changes expected October 2019
- Medicaid PA criteria will be posted behind the provider portal in the near future

Limited Specialty Pharmacy Network

New Limited Specialty Pharmacy Network EFFECTIVE 4/1/2019

- MEDICAID members only and for select classes of medications that are primarily used for chronic conditions
- WHY?
  - Improve quality of care
  - Ensure members are getting assistance with disease management and adherence
- WHAT drugs are included in the network?
  - Drug List is available by calling Network Management and will be posted in the provider portal in the near future
- HOW were Pharmacies Selected?
  - Number of criteria including specialty certification, disease management
  - 5 Pharmacies: ALL CVS Specialty/Caremark (4 locations PA, CA, KS, IL)

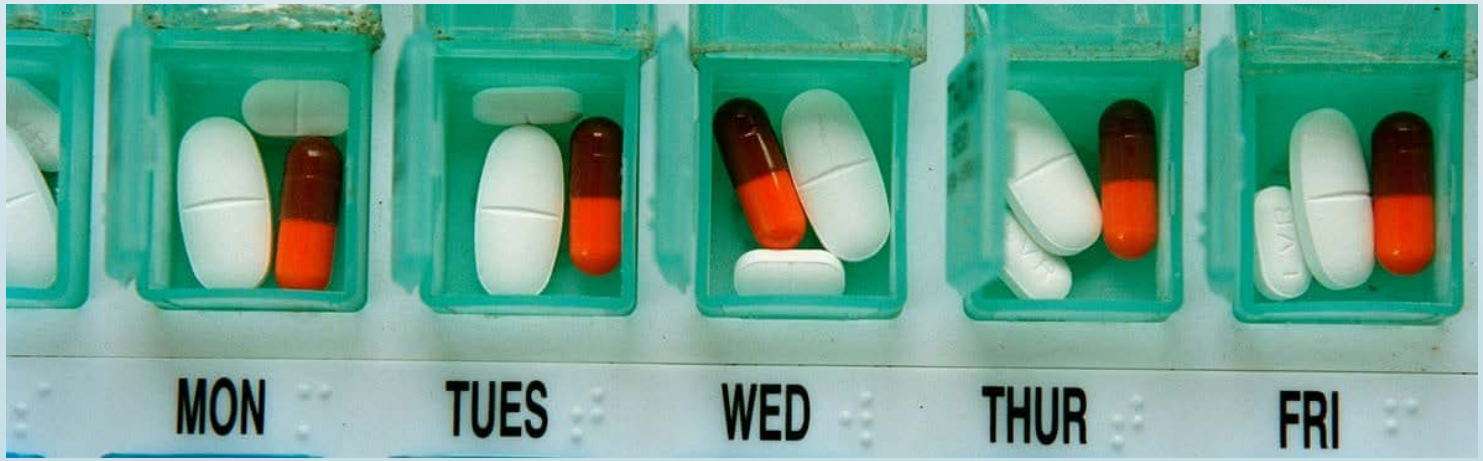
    Exactus Pharmacy (FL)

Adherence

Adhering (verb) is defined as:

"to stay attached or cause to adhere or make stick"

- How do we help our members with adherence?
  - Target Members
  - Assist Providers
  - Health Plan Benefits and Formulary



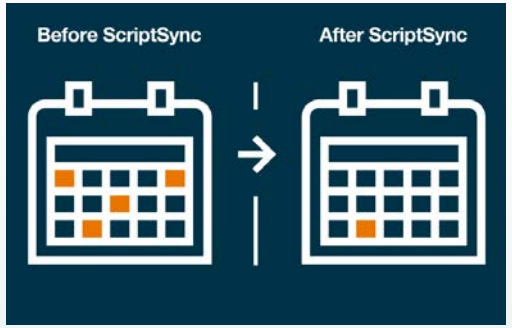
Medicare Adherence

- Target Members
  - Letters to members
  - Script Sync (CVS only)
  - Multi- Dose Packaging (CVS only)
- Assist Providers
  - Letters on non-adherence or gaps
  - 30-90 day Prescriptions
  - RxEffect for eligible providers or provider groups
- Health Plan (Medicare Advantage or Value plan)
  - No copays for Tier 1 (30 or 90 day supply)
  - No copays for Tier 2 with 90 day mail order supply
  - REDUCED copays for Tier 3 with 90 day mail order supply

Medicaid Adherence

- Target Members
  - Letters to members
  - MedSync (where available)
  - Multi- Dose Packaging (CVS only)
- Assist Providers
  - Letters on non-adherence or gaps
- Health Plan
  - Pharmacy Network Support

Adherence Tools



ScriptSync or MedSync:

- Pick up multiple prescriptions at the same time

Multidose Packaging:

- 30 day supply of medication individually packaged and labeled by dose, date and time
- Delivered to the member's home
- Members enroll through phone or online

Smartphone APP's

- CVS refill reminders & pill schedule
- Others

Managing Opioids in Arizona

HB2075 – signed in to law February 14th, 2019

- Electronic Prescribing of Opioids will go into effect for ALL Arizona counties 1/1/2020 and retroactive to 12/31/2018
  - ALL Schedule II opioid prescriptions will need to be transmitted electronically 1/1/2020

90 MME Dosage Limits

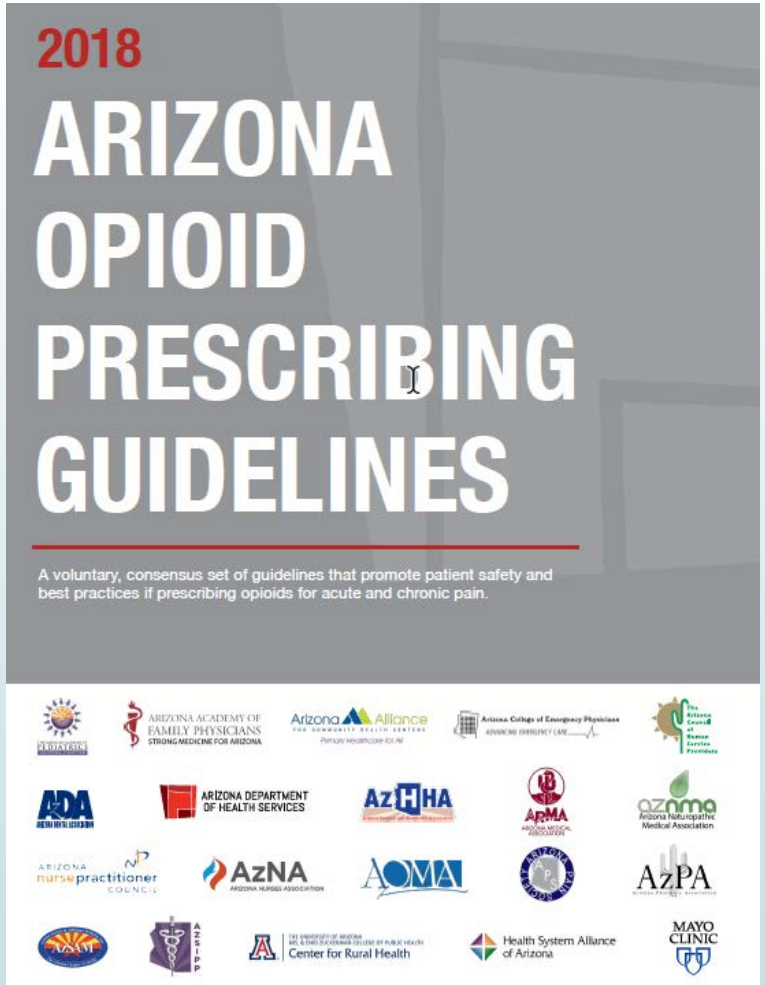
- All new prescriptions for opioids should be <90 MME/day (exemptions permitted)
- If a non-exempt patient requires a higher initial dose, prescribers are required to contact a board-certified pain physician OR call an opioid assistance and referral call service for a consult.
- OARLine: Opioid Assistance + Referral Line for Arizona Providers: 888-688-4222
  - This referral line is an excellent resource for free, real-time consultations for clinicians with complex patients with pain and opioid use disorder

Managing Opioids in Arizona

Naloxone Prescribing:

- Consider co-prescribing naloxone to patients at higher risk for overdose:
  - history of overdose or substance use
  - opioid dosages ≥50 MME/day
  - concurrent sedating medications (such as benzodiazepines, hypnotics, muscle relaxants)
  - diseases such as COPD, Asthma, or sleep apnea
- Standing order for naloxone in Arizona and available without a prescription

Managing Opioids in Arizona



Safety Concern – Drug Utilization Review

Citalopram:

- FDA issued a warning March of 2012 indicating that patients on doses of greater than 40 mg per day, due to increased risk of heart rhythm disorders or 20 mg per day if >60 years of age
- Recommendation
  - If a patient is seeing a BH provider or PCP, make sure you are aware of all medications being prescribed
  - EKG for member on high dose and that may be at risk
  - Watch for potential drug interactions

Quality Improvement

What is Quality Improvement

- Objectively monitors and evaluates the:
  - quality, appropriateness and outcome of care and services
  - structures and processes by which they are delivered to members
- Continuously pursues opportunities for improvement and problem resolution.

Quality Improvement Activities

- Access to and availability of care
- Provider satisfaction
- Clinical practice guidelines
- Under/over utilization
- Adverse outcomes/sentinel events
- Medical record keeping practices
- HEDIS and CAHPS results
- Performance Improvement Measures
- Performance Improvement Projects

Quality Improvement Team

- QI Director
- QI Manager
- QI Project Managers
- QI Supervisor
- Quality Practice Advisors *(newest addition to QI family)*
- QI Coordinators
- Quality Gap Coordinators
- Maternal Child Health Team
- DDD Liaison
- QI Specialist RNs
- QI Data Analyst

Quality Practice Advisor (QPA)

- New role for Care1st
- Part of the strategic program under WellCare to engage providers and educate on quality metrics
- Provider facing team of clinicians
- Works closely with Network Management
- Bridges the gap between provider and the plan for clinical initiatives
- Acts as subject matter experts for quality measures

Quality Practice Advisors
Roles and Responsibilities

QPAs enhance the working relationship between provider practices and Care1st:

- Provides education on
  - Quality measures
    - Examples of quality measures
      - Cervical Cancer screenings, Breast Cancer screenings, Diabetes management, Medication adherence, Rheumatoid Arthritis Management, Care for Older Adults
  - CAHPS
  - Appropriate medical record documentation
  - Appropriate coding
- Supports the development & implementation of
  - Quality Improvement interventions
  - Audits in relation to providers

Quality Practice Advisors
Roles and Responsibilities

- Tracks and trends provider performance data to identify and strategize opportunities for improvement
- Identifies specific practice needs where Care1st can offer support
- Partners with providers to increase member engagement

Quality Practice Advisors
Roles and Responsibilities

- Distributes gap reports
- Works with providers on addressing clinical care gaps
- Shares health plan resources to provider to aid in member engagement

Engagement

- QPAs will interact with providers/groups via
  - In person contact (required quarterly)
  - Phone
  - Email (via secured messaging as needed)
  - Mail
    - Distribution of clinical flyers
    - Brochures
    - Pamphlets
    - Posters
- It is important for providers/groups to interact with their QPA as the interaction aids both provider and plan in achieving quality scores

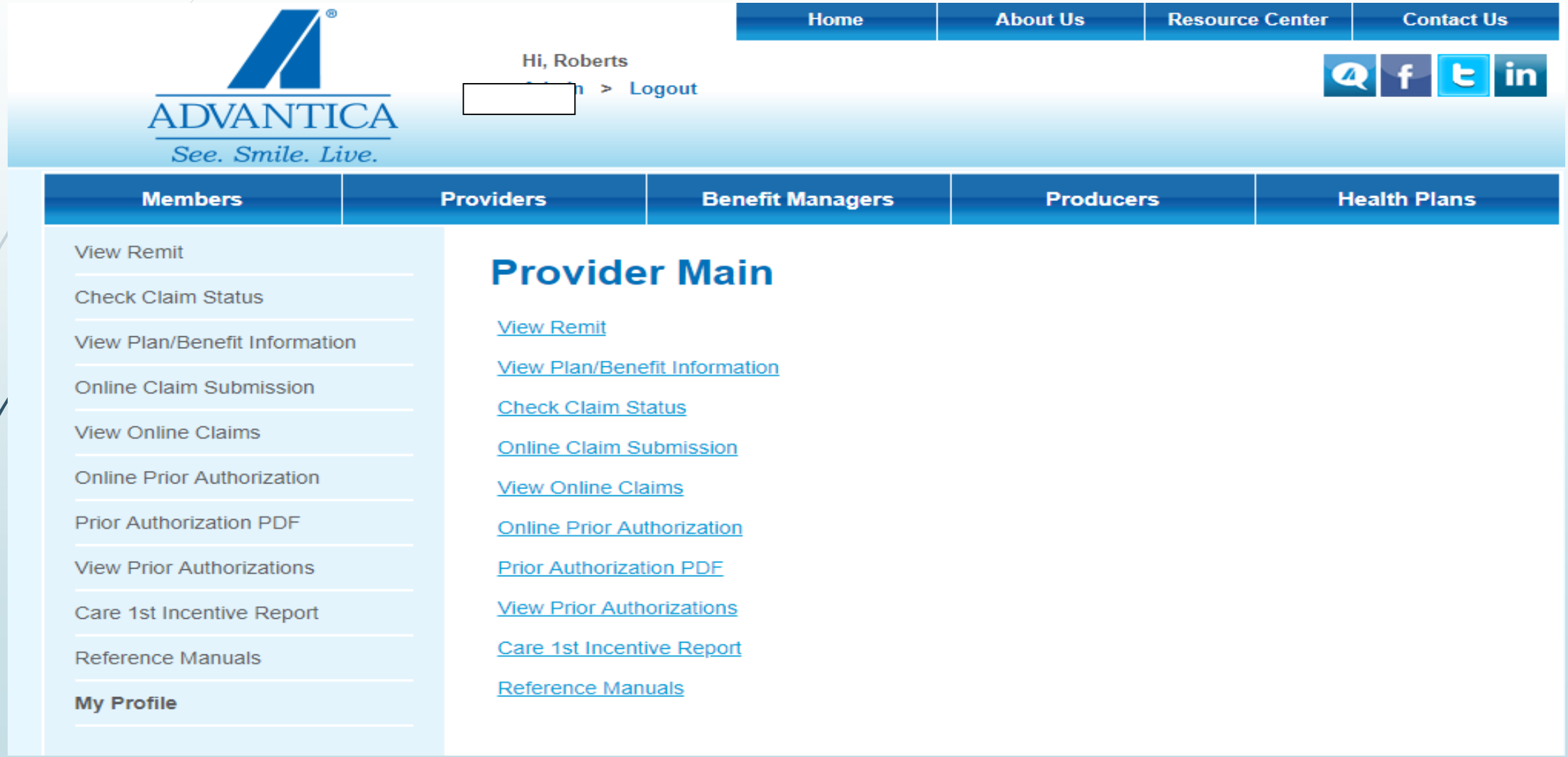
Dental

Dental
Website & Benefit Information

https://www.advanticabenefits.com/

- Advantica Online Provider Portal
  - https://www.advanticabenefits.com/Providers/Login?redir=%2fProviders%2fMain
- Dental Clinical and Billing Guidelines
  - Provider > Provider Login > Log on > Reference Manuals
  - Guidelines are also available on the Care1st website at: https://www.care1staz.com/az/providers/dental.asp

Dental
Advantica Provider Portal



Dental Claims

Electronic Data Interchange (EDI)

- CHANGE Healthcare (fka Emdeon)
  - Contact your software vendor to set up electronic submissions to CHANGE Healthcare. Make sure you provide the Advantica Payer ID 43168.
  - For CHANGE Healthcare Dental Connect support or questions 888-255-7293 or https://www.dentalproducts@changehealthcare.com or https://www.dentalsupport@changehealthcare.com
- EHG EDI Health Group, Inc. DentalXChange
  - Enroll online https://www.dentalxchange.com/partners/WebClaim or call 800-576-6412, ext. 455, Advantica Payer ID 43168
- Tesia
  - Enroll online https://www.tesia.com or call 800-724-7240, Advantica Payer ID 43168
- Advantica Provider Web Portal
  - Register at https://www.advanticabenefits.com/providers

Dental Claims

Electronic Funds Transfer (EFT)

- Advantica partnered with RedCard effective 2/1/17
- Enrollment is easy
  - Enroll online at https://enroll.ach835.com/new
  - Reference Document to assist you with enrolling located on Advantica Website: https://www.advanticabenefits.com/PDFs/AdvanticaBenefits/DocManagement/RedCard_EFT_and_ERA_Enrollment_Portalfo9_67780_27_03_2017.pdf

EFT Benefits

- Increase Staff Productivity
- Reduce risk of theft or fraud
- Achieve more predictable cash flow

Dental Claims

Electronic Remittance Advice (ERA)

- Advantica partnered with RedCard effective 2/1/17
- Enrollment is easy
  - Enroll online at https://enroll.ach835.com/new
  - Reference Document to assist you with enrolling can be found on the Advantica Website at https://www.advanticabenefits.com/PDFs/AdvanticaBenefits/DocManagement/RedCard_EFT_and_ERA_Enrollment_Portalfo9_67780_27_03_2017.pdf
  - You will receive paper remits for 3 pay periods after you enroll for ERA. After that time, you will only receive electronic remits

Electronic Attachment Transmittals

- Submit attachment using NEA-Fast
  - Note: NEA is now NEA powered by VYNE
- To Register:
  - Register online at https://reg.nea-fast.com/ and click on “I am a new client”, choose your location and then click “Next”
  - Register via phone by calling 800-782-5150

Dental
Claims

Top 5 Claims Denials, March 2019

1. Duplicate services previously submitted and processed
2. FQHC claims must be submitted with the facility NPI. Please resubmit
3. Patient chart notes must be submitted for $1000.00 Emergency Adult Benefit consideration. Please refer to AHCCCS guidelines for additional radiograph submission requirements
4. Service does not qualify for $1000 Emergency Adult Benefit
5. Benefits are not available to the same provider/office within 2 years of original service

Dental
Claim Tips

- Guidelines & documentation requirements are available at:
  - Advantica Website - https://www.advanticabenefits.com
    - Provider > Provider Login > Log on > Reference Manuals
  - Care1st Website – https://www.care1staz.com
    - Providers > Dental

- When submitting a COB claim – Please ensure primary carrier information is included on claim form:
  - Subscriber's Name
  - Date of Birth
  - Primary Insurance Member ID Number
  - Employer Group

Dental
Waste & Abuse

The following areas are reviewed for Waste and Abuse:

1. High incidence of restorative
2. High incidence of OL and OB restorations
3. High frequency of occlusal restorations on newly erupted teeth
4. High incidence of diagnostic/preventive services

Dental
Adult AHCCC Acute Emergency Benefit

- Effective Date – October 1, 2017, Acute members are covered over the age of 21 for emergency dental services up to $1,000 per contract year (i.e. October 1-September 30)
  - Services such as repair of fractures to the facial structures are not subject to the $1,000 per contract year
  - Services that fall in the exception for transplant cases are not subject to the $1000 per contract year
  - Prescription drugs are not included in the $1,000 per contract year
- A dental emergency is defined as an acute disorder of oral health resulting in severe pain and/or infection as a result of pathology or trauma
- Covered Services
  - Emergency oral diagnostic examinations – limited problem focused
  - Radiographs limited to symptomatic teeth
  - Composite resin fillings due to recent tooth fracture for anterior teeth

Dental
Adult AHCCC Acute Emergency Benefit - *Cont*

- Covered Services – *continued*
  - Prefabricated crowns to eliminate pain due to recent tooth fracture only
  - Re-cementation of crowns, inlays, onlays, and bridges
  - Pulp cap
  - Root canals and pulpotomies when indicated for the treatment of acute infection or to eliminate pain with a favorable diagnosis
  - Immediate and palliative procedures including extraction for the relief of pain
  - Tooth re-implantation of accidentally avulsed anterior teeth
  - Preoperative procedures and anesthesia – must meet GA requirements. Anesthesia services are inclusive of the $1,000 benefit
  - Permanent crowns limited to endodontically treated teeth

Dental

Adult AHCCC Acute Emergency Benefit - *Cont*

- Not covered with this benefit
  - Fixed bridgework
  - Dentures
  - Diagnosis and treatment of TMD or TMJ
- Prior authorization is not required. Should you submit a prior authorization it will be returned (not processed) advising it is not required
- All emergency dental services are subject to retrospective review by Advantica to determine if they satisfy the criteria for a dental emergency
- Handling of services that exceed the $1,000 benefit limit:
  - The provider must supply the member a document describing the services and the cost of those services. Prior to delivery of services the patient must sign and date a document indicating responsibility for the cost beyond the $1,000 limitation

Dental
Prior Authorization Tips

- Services that require prior auth identified with an * on Clinical and Billing Guidelines.
- Submit prior auth requests online for faster turnaround time
- Processing Timeframes
  - Standard – Requests processed within 4 business days
  - Urgent/Expedited - Requests are processed within 72 hours of receipt of request
- Prior auth requests for general anesthesia should include name of anesthesiologist or anesthesia group and estimated treatment time.
- Prior auth request for general anesthesia also should include detailed narrative as to why anesthesia is requested and chart notes that include previous experience with failed attempts to treat (i.e. Nitrous, OCS, etc.). Medical and behavioral conditions should also be included

Dental
Prior Authorization Tips – *Cont*

- Periodontal scaling and root planning prior auth submissions require X-rays, perio charting and documentation of patient's oral hygiene.
- D4355 is not covered when perio charting is completed.
- Prior auth appeals require an Appointment of Representation (AOR), if submitted by provider
- Prior auth appeals are to be submitted and handled by Care1st Claims Disputes & Appeals Team
- Guidelines & documentation requirements are available at:
  - Advantica Website - https://www.advanticabenefits.com
    - Providers > Provider Login > Log on > Reference Manuals
  - Care1st Website – https://www.care1staz.com
    - Care1st > Providers > Dental

Dental
Prior Authorization Tips – *Cont*

- D9230 not covered with D9248
- D9230 Prior auth is not required for patients under age 11
- D9420 not covered on same day as hospital or ACS procedure, service/treatment
- D0210 and D0330 cannot be billed in conjunction and only 1 allowed every 36 months
- Permanent crowns and crown build-ups covered only if tooth was endo treated
- Permanent crowns not covered for patients under 18 years of age
- Space maintainers for 1st primary molars not covered after 6 year molars have erupted into occlusion
- FQHC Tips
  - Please add “FQHC” in the remarks section of the ADA form and bill with appropriate fees

Advantica Customer Service: 800-429-0495

END

Questions?