Montgomery County Medical Society

CareFirst BlueCross BlueShield Presentation

December 7, 2016

Agenda

- Federal Employee Program Benefit Changes for 2017
- State of Maryland Changes for 2017
- Health Care Exchange
- Self-Service Tools
- CareFirst Updates and Reminders

Federal Employee Program Benefit Changes for 2017

Sleep Studies

Basic Option

2016 – Preferred copayment for sleep studies is $100.
No prior approval required.

2017 – Preferred copayment for sleep studies is $40.

Basic and Standard Option

Prior approval is required for all Sleep Studies performed outside of the home setting.

Pages 41 and 87 in the Service Benefit Plan Brochure

Applied Behavior Analysis (ABA)

Basic and Standard Option

2016 – Not Covered

2017 – Standard Option – Preferred facilities: member pays 15% of the Plan allowance (deductible applies).

Basic Option – Preferred facilities: member pays $30 copayment, per day, per facility.

*Covered for an autism spectrum disorder.

*Prior approval is required for ABA and all related services, including assessments, evaluations, and treatments.

Pages 41 and 87 in the Service Benefit Plan Brochure

Preventive Care Benefits - BRCA

Basic and Standard Option

2016 – Required prior approval and genetic counseling and evaluation.
Member had no history of breast or ovarian cancer.
Member had to meet family history criteria.
One test per lifetime, regardless of whether or not the test was performed as a preventive or as a diagnostic service.

2017 – Expanding eligibility for BRCA related testing for members with a first - or-second degree relative diagnosed with pancreatic or prostate cancer.

Page 44 in the Service Benefit Plan Brochure

Preventive Care Benefits – Screening Mammography Using Digital Technology

Basic and Standard Option

2016 – Diagnostic benefits were provided.

2017 – Covered as preventive care and limited to one per calendar year.

Page 42 in the Service Benefit Plan Brochure

Nonsurgical Treatment of Amblyopia and Strabismus

Basic and Standard Option

2016 – Diagnostic benefits were provided for children from birth through age 18.

2017 – Diagnostic benefits are now provided for children from birth through age 21.

Page 57 in the Service Benefit Plan Brochure

Gender Reassignment Surgery

Basic and Standard Option

2016 – Not covered.

2017 – Standard Option: Preferred – member pays 15% of Plan allowance.

Basic Option: Preferred – member pays $150 copayment per performing surgeon, for surgical procedures performed in an office setting.
Preferred – member pays $200 copayment per performing surgeon for surgical procedures performed in all other settings.

*For adult members age 18 and over.
*Prior approval and pre-certification is required for gender reassignment surgery.
*See Service Benefit Plan Brochure for surgical limitations.

Page 68 in the Service Benefit Plan Brochure

State of Maryland Changes for 2017

State of Maryland

The State of Maryland is expanding their wellness program as it relates to the co-pay to also include specialists. As a result they will be modifying their identification cards to remove the co-pay information.

You can verify this information by accessing the CareFirst self-service tools which include CareFirst Direct at www.carefirst.com/carefirstdirect or the voice response unit CareFirst on Call.

Please visit www.carefirst.com/statemd for additional information regarding 2017 benefit information.

Health Care Exchange

Exchange Open Enrollment

Open enrollment to purchase a qualified health plan for 2017 begins 11/1/16 and ends 1/31/17.

The invoices/bills that come from CareFirst are not verification of coverage. The member's coverage must be verified in CareFirst Direct.

Self-Service Tools

Use CareFirst Self-Service Tools

- Use the following CareFirst self-service tools to obtain eligibility, benefits and claim status

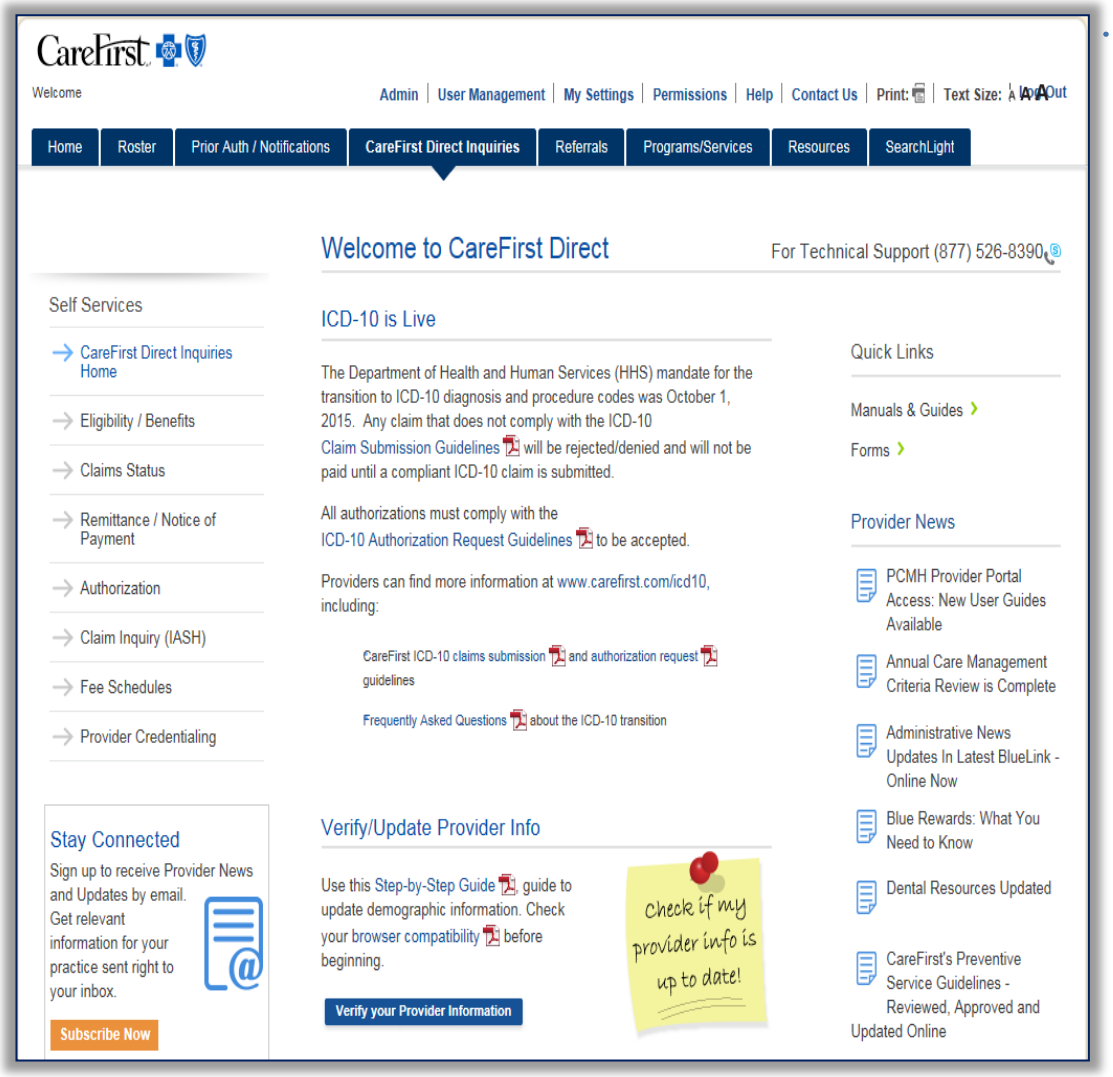
  - CareFirst on Call - Voice Response Unit - 202-479-6560 or 800-842-5975

  - CareFirst Direct – Register on www.carefirst.com to access the system

- Contact Provider Service areas only for complex issues and inquiries that require special handling

- Routine calls will be redirected to CareFirst Direct and/or CareFirst on Call

CareFirst Direct



- Free service
- View eligibility and benefits information
- View claim status, authorizations and referrals
- Avoid time-consuming phone calls
- Submit inquiries on your own time and receive a reference number
- Fee Schedule
- Submit inpatient notifications (authorizations) and outpatient prior-authorizations for some provider types
- Can perform provider updates that will enable providers to keep their information current
- Register for free training

CareFirst Updates and Reminders

Improving Account Security & User Experience

CareFirst Provider Portal Updates Are Coming….

- In an effort to improve security and the overall user experience, **effective December 17, 2016**, the CareFirst Provider Portal will include new features for your convenience and safety.
- **No action is needed right now**. However, when these security features are implemented, users will complete a **one-time account update** where they will be asked to provide a **unique email address for their User ID** (if a user performs work for multiple Tax IDs they can use the same email address for each of their User IDs).
- Individuals **utilizing the role of Office Manager** in the Provider Portal **will keep that role** if the system shows them regularly using this functionality.
- Any users who need to have access to a role/feature they currently don't have after updating their account will be able to access their Profile under the "Settings" link and **send a request to their Office Administrator**.
- Users will **no longer** be able to use any email address that contain the following. The system will display an error message letting you know that these email addresses are invalid.
    - info@
    - sales@
    - admin@
    - webmaster@
- In the coming week, we will provide you with more information including **User Guides, FAQs and On-Demand Tutorials** to make these changes as seamless as possible for you.

Verify and Update Your Provider Information Online – Today!

CareFirst requires all Professional providers verify their information twice per calendar year any time the practice information changes. Reviews, updates or changes can be made via the Provider Portal by logging on to www.carefirst.com/providers. Once the information is reviewed, if there are no changes, you still need to **click the 'Verify' button** so that we can validate that you have completed this process. Most updates are reflected in the Provider Portal within 24 to 48 hours.

The first validation requirement for Professional providers must be completed between January 1 and June 20, and the second validation should take place between July 1 and December 31, and should occur no less than 3 months after the first validation.

If you experience technical issues with updating the information online, contact the Help Desk at (877) 526-8390. If you would like additional training, you can enroll in the webinar session 'Update Provider Data Online – Prof.' at www.carefirst.com/cpet. Reviews, updates or changes can be made via the Provider Portal by logging on to www.carefirst.com/providers.

FEP Pre-Cert/Pre-Auth On-line

To obtain information on the FEP services that require pre-cert/pre-auth, access www.carefirst.com/preauth which takes the providers to www.fepblue.org. FEP determined that it was more accurate to be directed to the FEP website to get the most current information since this can change from year to year.

The pre-authorization requirements for Gender Dysphoria and Applied Behavior Analysis (ABA) assessment are outlined on Page 22 of the 2017 FEP Service Benefit brochure. Specific information for Gender Dysphoria can be located on pages 68-69 and for ABA on pages 55-56 and 88.

Medication Management and Electronic Pre-Authorization (ePA)

Effective January 1, 2017, pre-authorization is required for certain medications administered in outpatient facilities and home or office settings.

CareFirst has delegated the processing of these pre-authorizations to CVS Caremark.

Failure to obtain pre-authorization for these medications may result in the denial of the claim payment.

Pre-Authorizations should be submitted by logging in to www.carefirst.com/providerlogin and navigate to the *Pre-Auth/Notifications* tab to complete the request.

A complete list of all medications that require pre-authorization for CareFirst members is available at www.carefirst.com/preauth.

For more information on submitting prescription drug pre-authorizations electronically register for an upcoming 'Electronic Prior-Authorization (ePA) for Drugs' webinar at www.carefirst.com/cpet for call Provider Services at 877-228-7268.

Specialty Infusion Therapies

CareFirst has examined the cost differences for specialty infusion drugs and found that costs are significantly higher when they are administered in a hospital setting versus a non-hospital, office or home-based setting. These settings offer more flexible scheduling and are just as safe and more convenient for your patients to receive high-quality infusion care.

Site of Care

In early 2017, coverage for Remicade and IVIG infusion will be limited to administration at a non-hospital based setting unless medically necessary and approval is given.

This is part of CareFirst's effort to lower cost while providing quality care to our members.

Behavioral Health Treatment Services

CareFirst collaborates with Magellan to offer mental health services to your patients to help support them on the path to better health. These programs also help to support your behavioral health treatment recommendations.

- For patients who would benefit from real-time, two way conversations, there's Magellan Telehealth.
- For a patient who needs additional treatment options due to an alcohol or drug addiction, there's Medication-Assisted Therapy.
- For patients who have difficulty scheduling and maintaining appointments, talk to them about My Care Link Up.
- If your patient needs additional details or would like to talk to a mental health representative from Magellan, refer them to the Mental Health/Substance Abuse phone number listed on the back of their member ID card.

For more disease management information and clinical resources to help supplement your patient care efforts, login to the provider portal (CareFirst Direct), click on the Programs/Services tab, and then Clinical Resources.
Or, visit www.carefirst.com/clinicalresources.

**Magellan is an independent company providing mental health services to CareFirst members*

Various Chart Review Efforts

HEDIS – Health Plan Employer Data Information Set	HEDIS is a tool used by most of America's health plans to measure performance on important dimensions of care and service. The National Center for Quality Assurance (NCQA) is the monitoring/accrediting body. HEDIS is designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. CareFirst requests records from provider offices to review to make sure that we are meeting certain measures. Verscend was contracted by BCBSA so that plans could utilize them to request records for out of area members.
Risk Adjustment	Risk adjustment is a process for compensating carriers that acquire a member population with less than average health. This is a requirement by CMS of carriers who sell products under the ACA. Insurers pay in/out based on the risk associated with their individual and small group enrollee populations. As a result, the risk-adjustment model redistributes money from insurers with healthier patient populations to those with sicker patient populations. CareFirst uses HealthScape Advisors as consultants for Risk Adjustment and ArroHealth to actually request the medical records and conduct the chart review.
Risk Adjustment Data Validation (RADV)	RADV is essentially an audit of an audit. It audits the chart reviews that were done during Risk Adjustment. Like Risk Adjustment, it is a requirement of CMS. RADV is the process of verifying diagnosis codes submitted for payment are supported by medical record documentation. The purpose is to ensure risk adjusted payment integrity and accuracy. CareFirst is working with Cognisight to conduct this Initial Validation Audit (IVA).

- Any Questions?
- Thank You for Attending