AMBETTER FROM BUCKEYE HEALTH PLAN

2023 Provider Orientation

AGENDA

- **OVERVIEW**
  - Who We Are
  - Affordable Care Act
  - The Health Insurance Marketplace
  - Our Networks
- **WHAT YOU NEED TO KNOW**
  - Key Contact Information
  - Provider Manual
  - Provider Relations
  - Provider Secure Portal
  - Verification of Eligibility, Benefits and Cost Shares
  - Referrals
  - Prior Authorization
  - Claims, Billing and Payments
  - Complaints, Grievances and Appeals
  - Specialty Companies and Vendors
- **Q & A**

OVERVIEW

WE ARE

Ambetter.

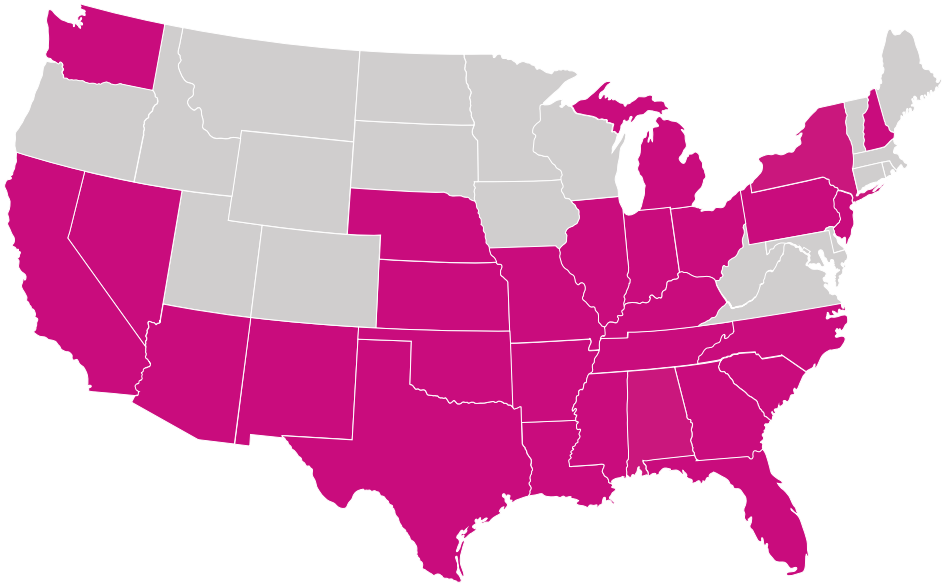
WE PROVIDE MARKET-LEADING, AFFORDABLE HEALTH INSURANCE ON THE MARKETPLACE.

#1 carrier
on the health insurance marketplace

2014
Year that Ambetter began

2.0M+
members insured

28
states

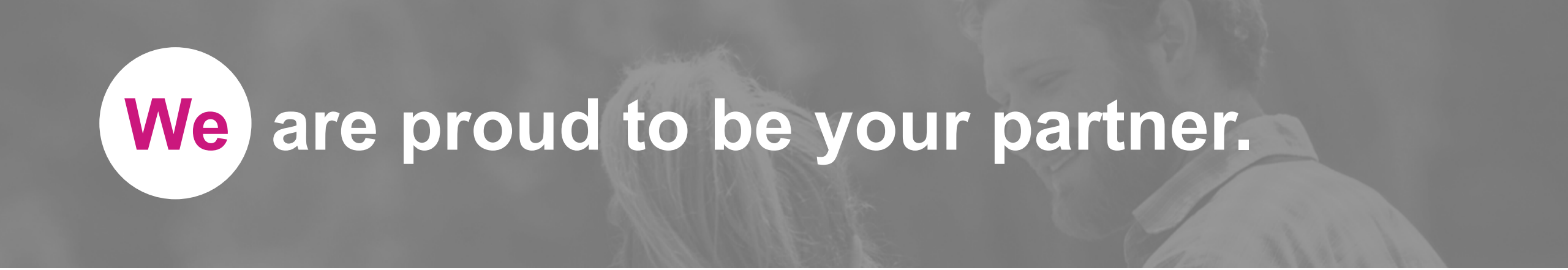


We target a focused demographic.

Lower income,
underinsured and uninsured

LOCAL APPROACH TO CARE

Ambetter delivers high quality, locally-based healthcare services to its members, with our providers benefiting from enhanced collaboration and strategic care coordination programs



We are proud to be your partner.

- The **Ambetter plan design philosophy** is to provide affordable care to individuals or families that need to purchase healthcare coverage on their own.
- **Our products** focus on various cost shares — many with low or no copay amounts — to meet the budget and utilization needs of these consumers. This gives our members the peace of mind that they have full comprehensive medical coverage.
- Additionally, the **emphasis on reducing barriers and improving access to care** mitigates the risk of individuals showing up without insurance (uncompensated care). Ambetter's generous cost-sharing initiatives lower patient financial responsibility while also reducing the amount that providers need to collect at time of service.
- Most importantly, Ambetter plans encourage members to establish relationships with their primary care providers to **achieve favorable health outcomes**.

THE AFFORDABLE CARE ACT

KEY OBJECTIVES OF THE AFFORDABLE CARE ACT (ACA):

- Increase access to quality health insurance
- Improve affordability

ADDITIONAL PARAMETERS:

- Dependent coverage to age 26
- Pre-existing condition insurance plan (high risk pools)
- No lifetime maximum benefits
- Preventative care covered at 100%
- Insurer minimum loss ratio (80% for individual coverage)

THE AFFORDABLE CARE ACT

REFORM THE COMMERCIAL INSURANCE MARKET – MARKETPLACE OR EXCHANGES

- No more underwriting – guaranteed issue
- Tax penalties for not purchasing insurance
- Minimum standards for coverage: benefits and cost sharing limits
- Subsidies for lower incomes (100% - 138% FPL)

HEALTH INSURANCE MARKETPLACE

ONLINE MARKETPLACE FOR PURCHASING HEALTH INSURANCE

POTENTIAL MEMBERS CAN:

- Register
- Determine eligibility for all health insurance programs (including Medicaid)
- Shop for plans
- Enroll in a plan
- Exchanges may be state-based, federally facilitated or state partnership – – Ohio ***is a Federally Facilitated Marketplace***

THE HEALTH INSURANCE MARKETPLACE IS THE ONLY WAY TO PURCHASE INSURANCE AND RECEIVE SUBSIDIES.

HEALTH INSURANCE MARKETPLACE

SUBSIDIES COME IN THE FORM OF:

- Advanced Premium Tax Credits (APTC)
- Cost Share Reductions (CSR)

ALL BENEFIT PLANS HAVE COST SHARES IN THE FORM OF COPAYS, COINSURANCE AND DEDUCTIBLES

- Some members will qualify for assistance with their cost shares based on their income level
- This assistance would be paid directly from the government to the member's health plan

OUR NETWORKS

NETWORKS BUILT TO

Offer More

- Ambetter now offers a robust suite of innovative networks that give members more coverage options to fit their needs and budget.
- By offering increased product options, Ambetter also benefits providers by giving them exclusive access to new patient populations.
- Each Ambetter network is designed to offer members a unique type of coverage option specific to their state. This means that member plans and benefits can vary, and there may be referral requirements for certain types of care to be covered.
- As a provider, it is important you confirm which network and plan a member is in before extending care. This information is located on the member's ID card and can also be confirmed when verifying the member's eligibility.

OUR INNOVATIVE

Networks

Bronze | Silver | Gold*: The Ambetter core network – our broadest network of healthcare providers and hospitals offering affordable care to individuals or families that need to purchase healthcare coverage on their own. Referrals aren't required.

Ambetter Virtual Access*: This network offers emphasizes licensed virtual primary care providers (PCPs) for members over the age of 18. Members have the ability to select an on-the-ground PCP upon request. In addition, All members can access our core network of on-the-ground providers and hospitals for additional healthcare needs when referred, as applicable, by their selected PCP. Ambetter Virtual Access networks can have referral requirements for certain types of care.

**Network availability varies by state.*

HOW TO IDENTIFY A MEMBER'S NETWORK

All members will receive an Ambetter member identification card. The ID card includes new information including:

- The Provider Network the member belongs to; and
- Any referral requirements based on the member's plan selection.
- You can find an example of the member ID card on our website: https://ambetter.buckeyehealthplan.com/provider-resources/manuals-and-forms/provider-id-card-samples.html

AMBETTER VIRTUAL ACCESS

- Ambetter Virtual Access leans into the changing dynamics of how providers are delivering care, and how members are seeking care, increasing access to primary and urgent care services in a nimble way.
- Ambetter Virtual Access utilizes a robust national network of virtually-based PCPs.
    - In some states members will have Teladoc PCPs and in other states members will have Babylon PCPs. **In Ohio, members will have a Babylon PCP.**
- The network centers on an online, easily accessible medical home offering, with key features such as:
    - Creates a patient-centered care plan within the app
    - Easy to access, member-friendly reminders for follow-ups, picking up prescriptions, etc.
    - Full incorporation of virtual behavioral health providers
- Note that in some states, Ambetter Virtual Access members will be enrolled in plans where a referral from a PCP is required in order to see a specialists.
    - In Ohio, members will be enrolled in plans that **DO NOT require referrals**. However, it is possible that you may see Ambetter Virtual Access members from other states with a different referral requirement. Always check the member's ID card to determine if a referral is or is not required.

WHAT YOU NEED TO KNOW

GETTING ACQUAINTED

KEY CONTACT INFORMATION

PHONE

1-855-766-1189

TTY/TDD

1-877-941-9236

WEB

https://www.buckeyehealthplan.com/providers.html

THE PROVIDER MANUAL

THE PROVIDER MANUAL IS YOUR COMPREHENSIVE GUIDE TO DOING BUSINESS WITH AMBETTER From Buckeye Health Plan.

The Manual includes a wide array of important information relevant to providers including, but not limited to:

- Network information
- Billing guidelines
- Claims information
- Regulatory information
- Key contact list
- Quality initiatives
- And much more!

The Provider Manual can be found in the Provider section of the Ambetter from Buckeye Health Plan website at ambetter.buckeyehealthplan.com

PROVIDER RELATIONS

- The **Ambetter from Buckeye Health Plan** Provider Services department includes trained Provider Relations staff who are available to respond quickly and efficiently to all provider inquiries or requests including, but not limited to:
  - Credentialing/Network status
  - Claims
  - Request for adding/deleting physicians to an existing group

- By calling **Ambetter from Buckeye Health Plan** Provider Services at **1-877-687-1189** providers will be able to access real time assistance for all their service needs

PROVIDER RELATIONS

- As an **Ambetter from Buckeye Health Plan** provider, you will have a dedicated Provider Engagement Administrators (PEA) available to assist you
- Our PEAs, serve as the primary liaisons between our health plan and provider network. You can find your assigned PEA at: https://www.buckeyehealthplan.com/providers/our-provider-engagement-administrators.html
- Your PEA is here to help with things like:

- ✓Inquiries related to administrative policies, procedures, and operational issues
- ✓Performance pattern monitoring
- ✓Contract clarification
- ✓Membership/provider roster questions
- ✓Secure Portal registration and Pay Span
- ✓Provider education
- ✓HEDIS/Care gap reviews
- ✓Financial analysis
- ✓EHR Utilization

PROVIDER NETWORK OPERATIONS

- Providers should submit updates to demographic data to OHIOCONTRACTING@CENTENE.COM within thirty days of the data change becoming effective.
- Forms to add new practitioners can be found on our website and should be submitted along with all credentialing documentation to OHIOCONTRACTING@CENTENE.COM
- Enrollments will be effective the date all clean documents are received.

Please send the following items to OHIOCONTRACTING@Centene.com:

✓Contract Clarification

✓Demographic information updates

✓Initiate credentialing of a new practitioner

✓Inquiries related to the status of a new practitioner or Join Our Network request

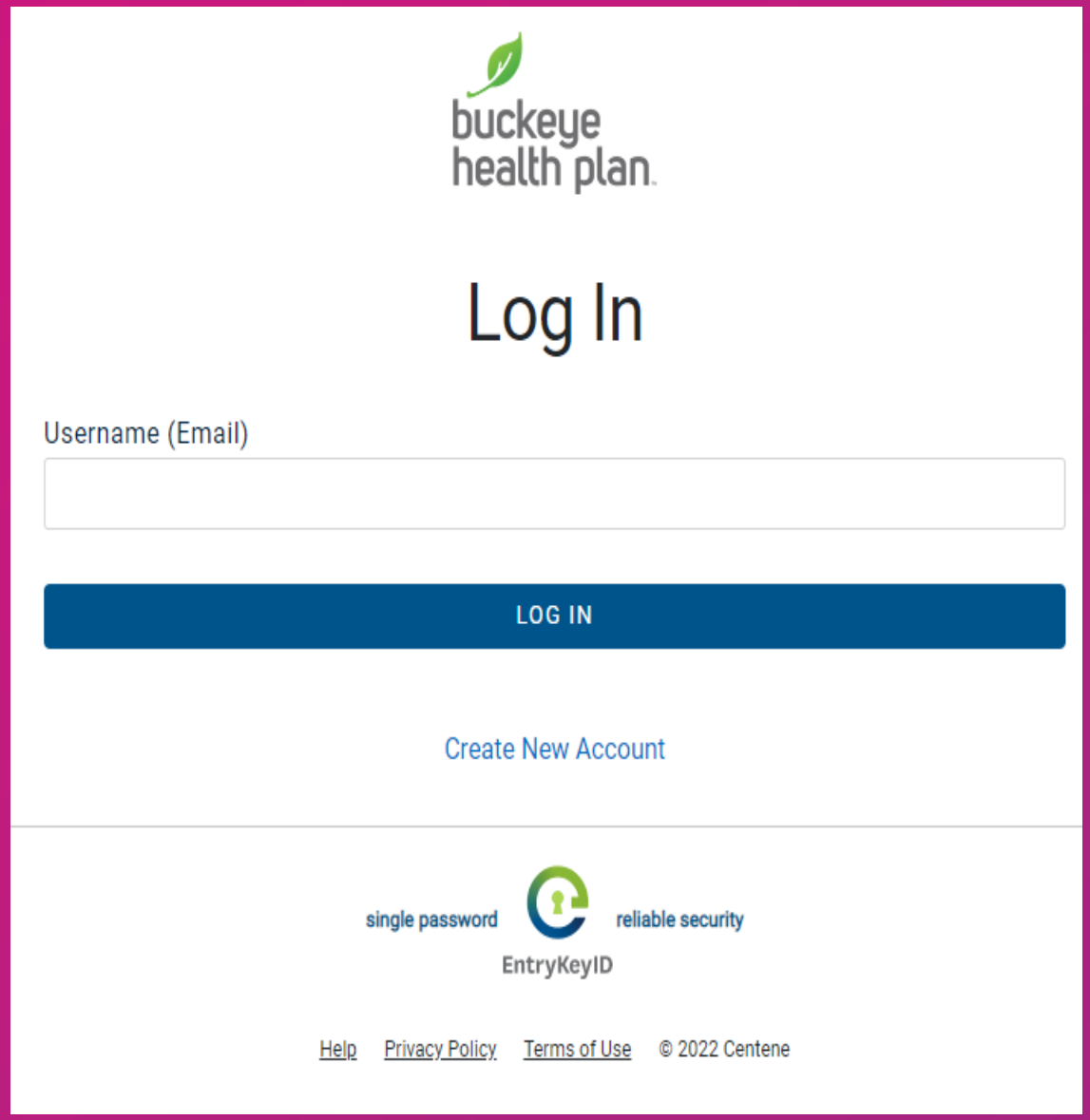
PROVIDER SECURE PORTAL

SECURE PROVIDER PORTAL

https://www.buckeyehealthplan.com/providers.html

Registration is easy!

Contact Provider services to get started!



SECURE PROVIDER PORTAL

WHAT'S ON THE SECURE PROVIDER PORTAL?

- Member eligibility & patient listings
- Health records & care gaps
- Authorizations
- Claims submissions & status
- Corrected claims & adjustments
- Payment history
- Monthly PCP cost reports
- Provider analytics reports

SECURE PROVIDER PORTAL

INSIGHTFUL REPORTS

PCP reports available on the secure provider portal are generated on a monthly basis and can be exported into a PDF or Excel format.

PCP REPORTS INCLUDE:

- Patient List with HEDIS Care Gaps
- Emergency Room Utilization
- Rx Claims Report
- High-Cost Claims

VERIFICATION OF ELIGIBILITY, BENEFITS AND COST SHARES

VERIFICATION OF ELIGIBILITY, BENEFITS AND COST SHARE

PROVIDERS MUST VERIFY MEMBER ELIGIBILITY

- Every time a member schedules an appointment
- When the member arrives for the appointment

PANEL STATUS

- Primary Care Physicians (PCPs) should confirm that a member is assigned to their patient panel
- This can be done via our Secure Provider Portal https://www.buckeyehealthplan.com/providers.html
- PCPs can still administer service if the member is not on their roster and they wish to have member assigned to them for future care

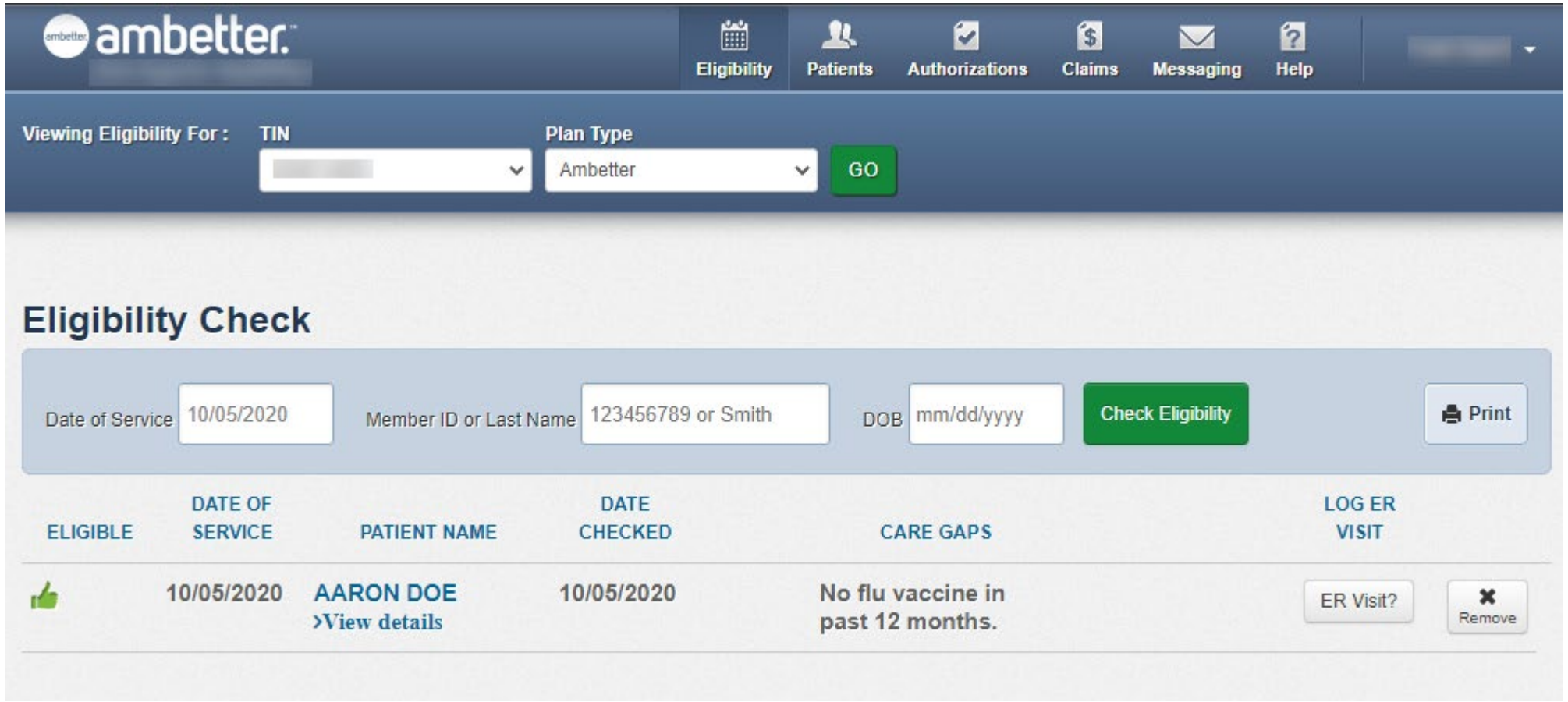
VERIFICATION OF ELIGIBILITY, BENEFITS AND COST SHARE

ELIGIBILITY, BENEFITS AND COST SHARES CAN BE VERIFIED IN 3 WAYS:

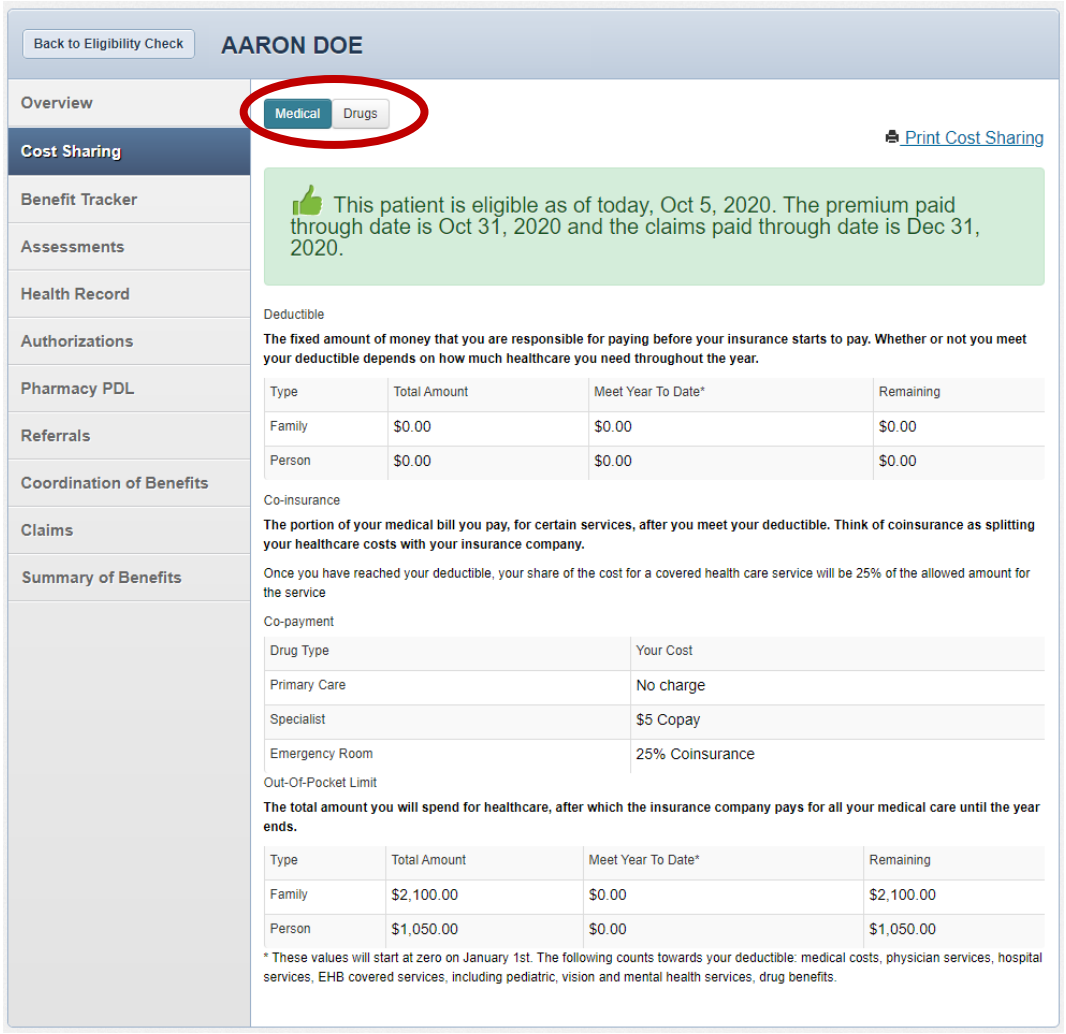
- ✓ **The Ambetter Secure Portal: https://www.buckeyehealthplan.com/providers.html**
  - If you are already a registered user of the **Ambetter from Buckeye Health Plan** secure portal, you do NOT need a separate registration!
- ✓ **24/7 Interactive Voice Response System**
  - Enter the Member ID Number and the month of service to check eligibility

Contact Provider Services: 1-877-687-1189

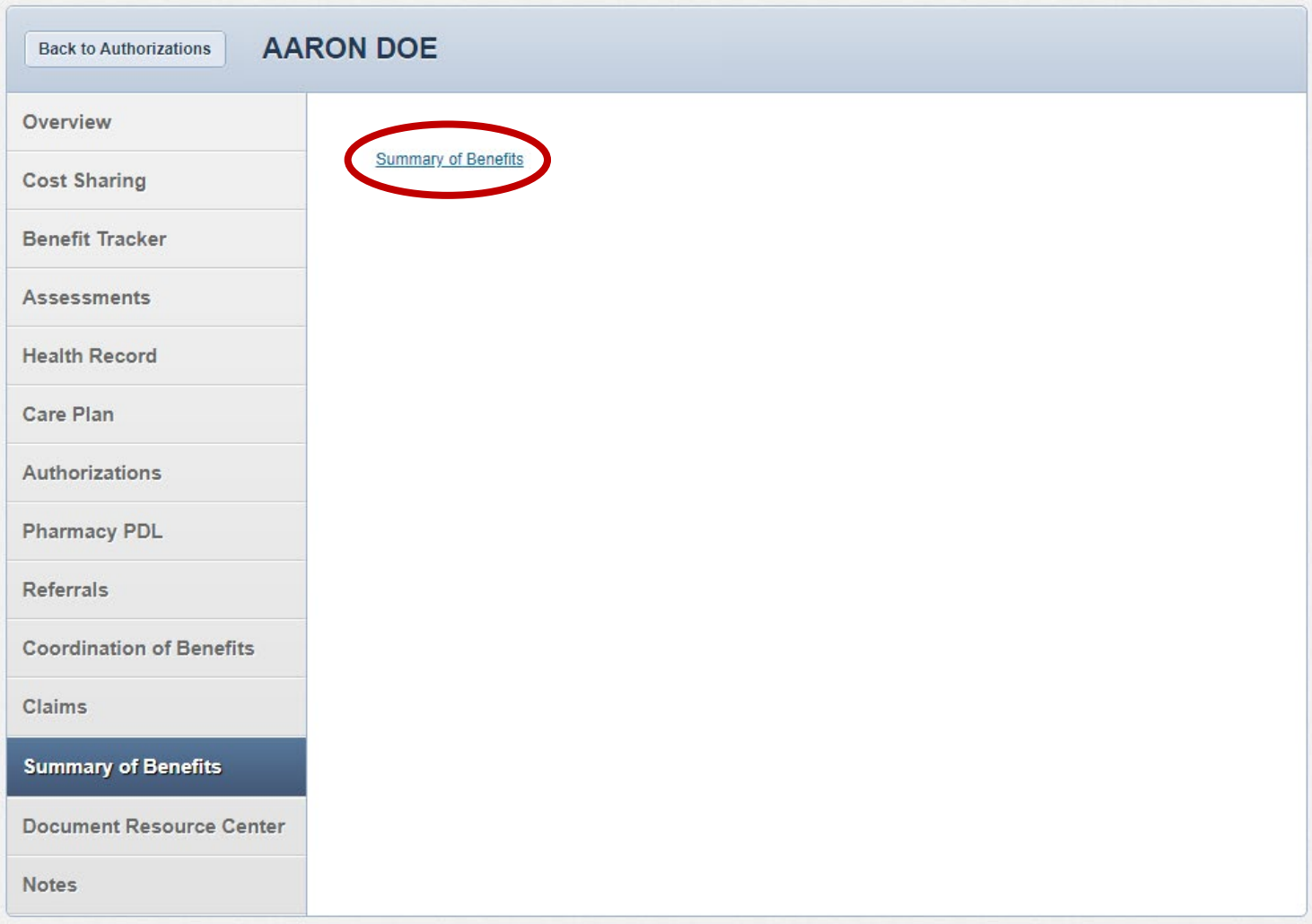
VERIFICATION OF ELIGIBILITY ON THE PORTAL



VERIFICATION OF COST SHARES ON THE PORTAL



VERIFICATION OF BENEFITS ON THE PORTAL



REFERRALS

AMBETTER REFERRAL REQUIREMENTS

- Some Ambetter plans have referral requirements.
- For services to be covered under these plans, they must be provided by or referred by a PCP.
- If a referral is not initiated, services performed outside of the member's assigned provider or primary care group will be denied.
- Prior authorization requirements will also apply, as necessary.
- Referral requirements are reiterated throughout the Ambetter Guide and member access experiences to ensure members understand the rules associated with their plan.
- Referring providers can use our Secure Provider Portal to initiate referrals on behalf of members.

EXEMPTIONS TO REFERRAL REQUIREMENTS

The following services are **exempt** from referral requirements:

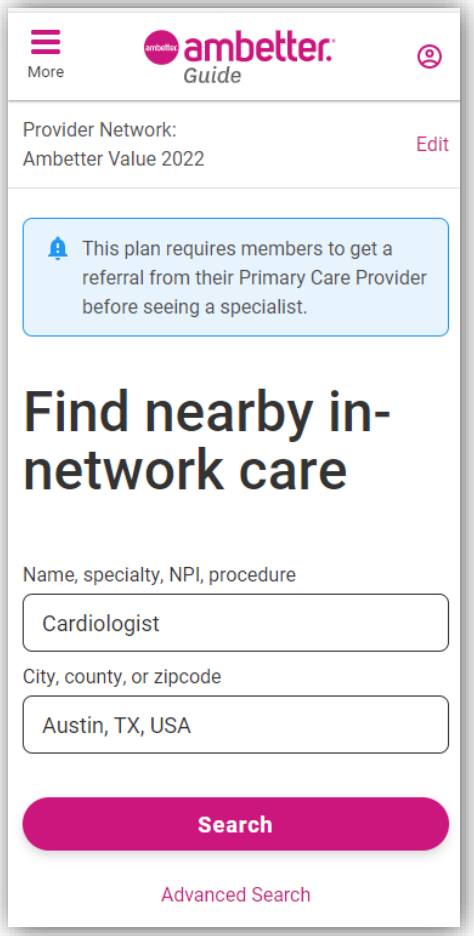
- Emergency or urgent care services
- In-network mental, behavioral health and substance abuse disorder services
- Obstetrical or gynecological services
- Labs, X-Ray/Imaging, Anesthesiology

Prior authorization requirements will also apply, as necessary.

AMBETTER REFERRAL REQUIREMENTS

Ambetter Plan	Referral Requirement?
Gold / Silver / Bronze	No
Ambetter Virtual Access	No

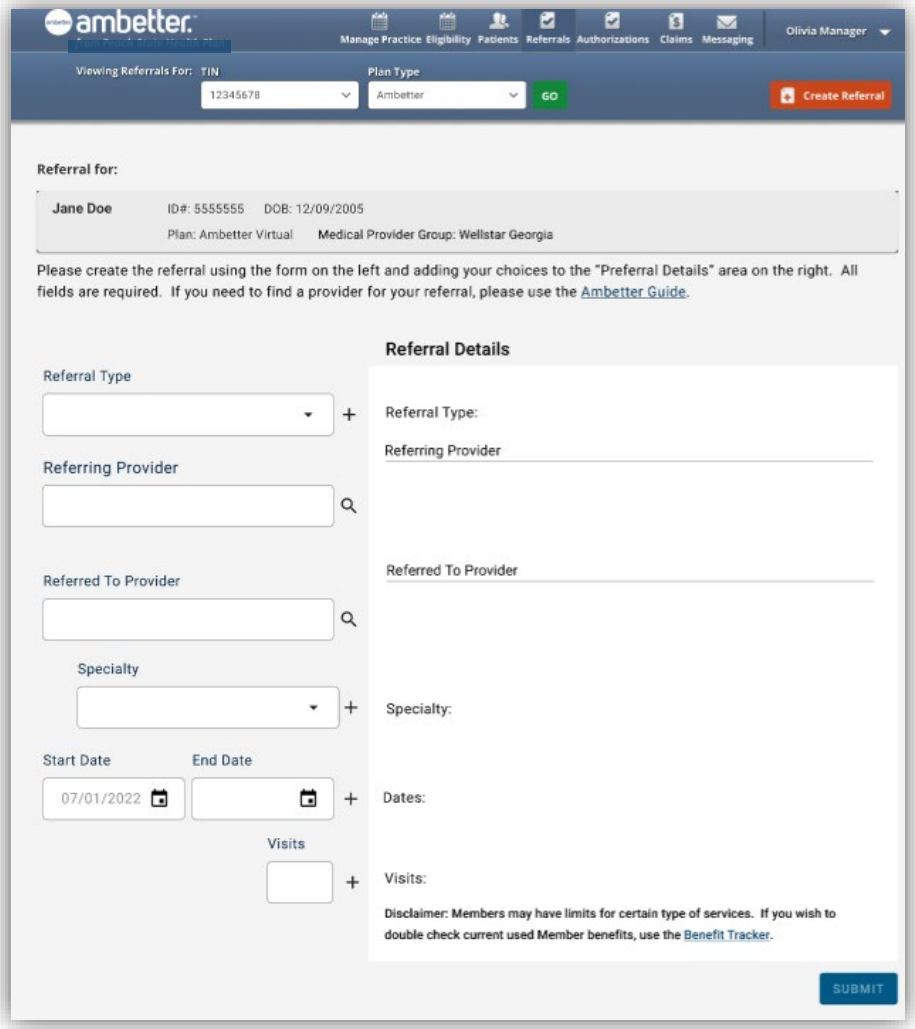
MAKING AN AMBETTER VIRTUAL ACCESS REFERRAL



1. Go to Ambetter Guide: https://guide.ambetterhealth.com/
2. Click the option for “Your Home State”
3. On the next screen, set the state field to the member’s home state. If a year field is present (e.g., during Open Enrollment), set it to the current year. Click the button to advance.
4. On the next screen, select the Ambetter Virtual Access option. Click the button to advance.
    1. If you do not see an Ambetter Virtual Access option, go back to the prior screen and make sure you have the state (and year, if present) set correctly.
5. The next screen includes fields for (1) a search term and (2) the search location.
    1. The search term field has no default. Enter the specialty you wish to search.
    2. The search location field defaults to the location set by your internet service provider. Set the search location to a ZIP or city appropriate for the member.
6. Submit the search. Results will load on the next screen.
7. Click through on any result to see full details about the provider, including their NPI.

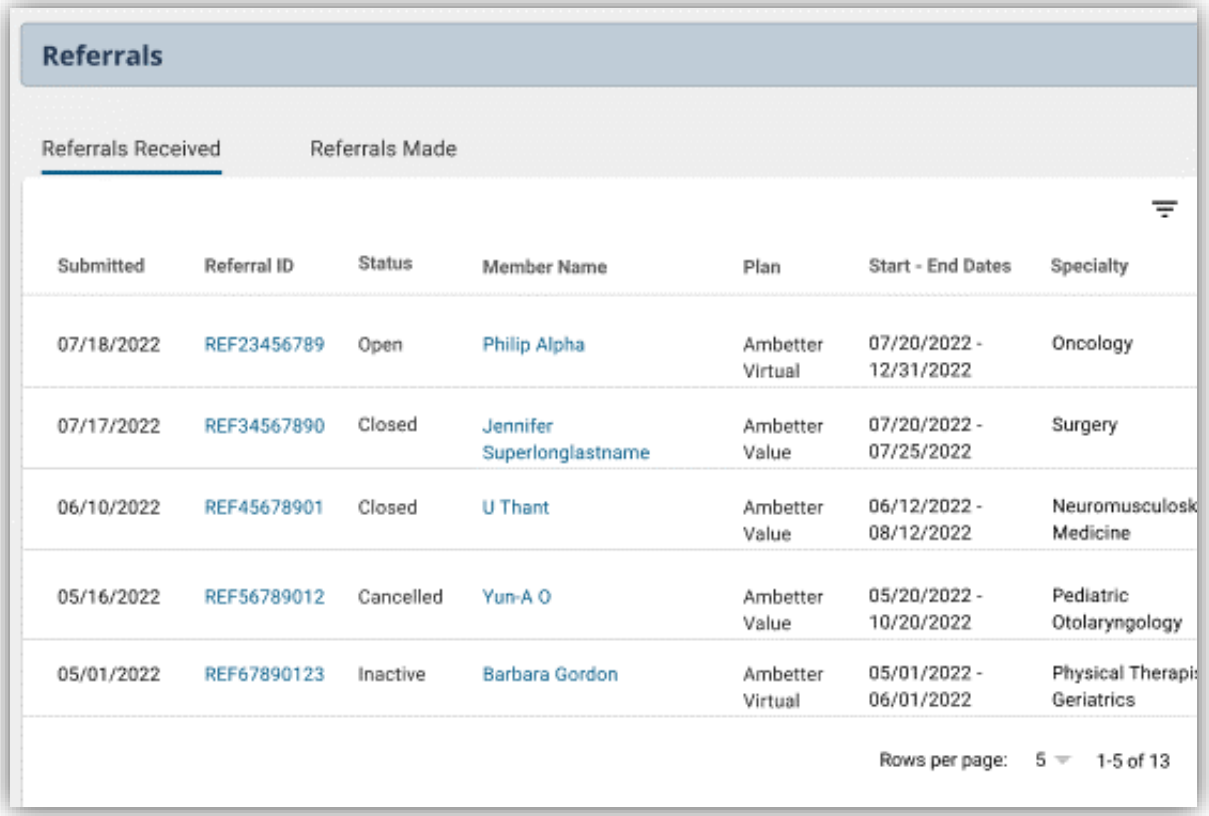
MAKING A REFERRAL: SECURE PROVIDER PORTAL

1. Click on the “Referrals” tab at the top of the screen.
2. Click the “Create Referral” button.
3. Enter the NPI into the Provider Portal Referral Intake field to find the provider you chose.
4. Complete the remaining fields in the PCP Referral form.



RECEIVING A REFERRAL

1. Once referred to you for care outside of their PCP, a member will set up an appointment.
2. Log in to the provider portal.
3. Navigate to ‘Referrals’ tab at the top.
4. Click on ‘Referrals Received’ to see the referral tracking table.
5. When you’re ready to submit a claim for the referred service, reference this table for the referral ID/REF#.
6. Submit claims form with the REF#.
7. **Claim form MUST include a REF# if a referral is required for the service**. If no REF# is submitted, the claim will be denied.



PRIOR AUTHORIZATION

HOW TO SECURE PRIOR AUTHORIZATION

NEED PRIOR AUTHORIZATION? IT can be requested in THE FOLLOWING ways:

✓ Secure Web Portal

https://www.buckeyehealthplan.com/providers.html

This is the preferred and fastest method.

✓ Phone

1-877-687-1189

✓ Fax

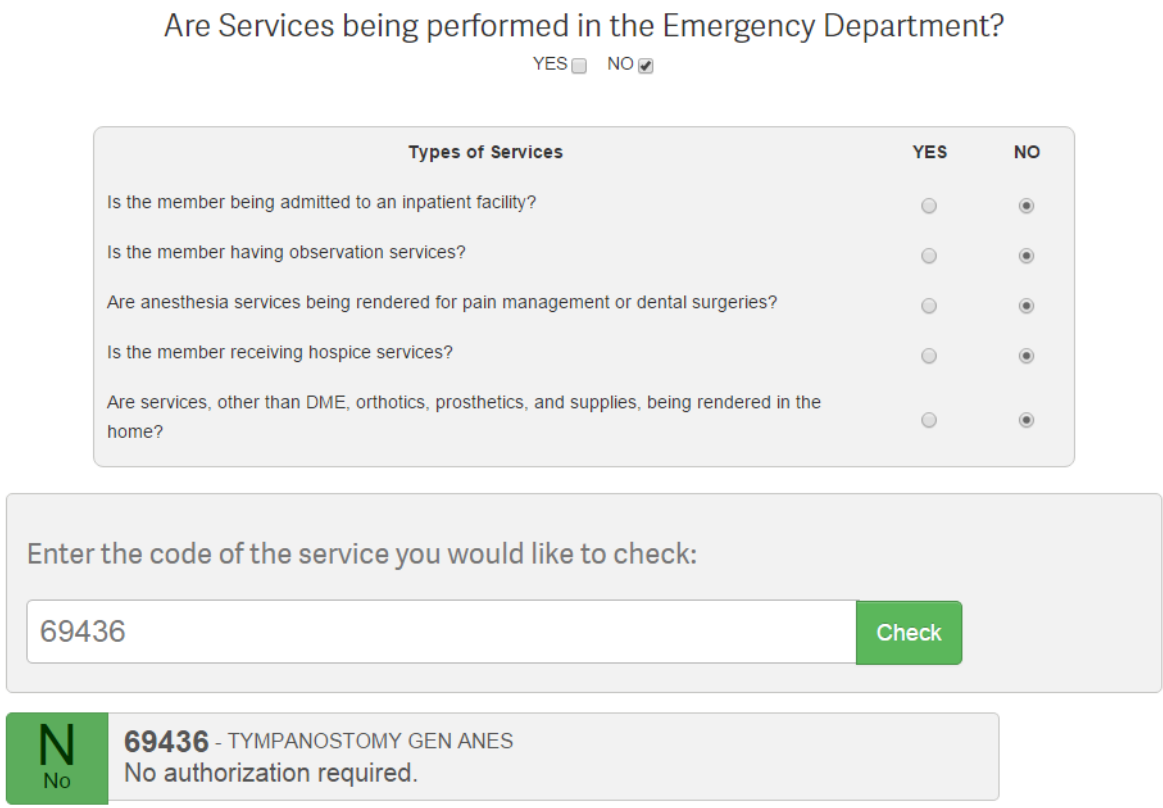
1-888-241-0664

After normal business hours and on holidays, calls are directed to the plan's 24-hour nurse advice line. Notification of authorization will be returned via phone, fax or web.

IS PRIOR AUTHORIZATION NEEDED?

- Use the **Pre-Auth Needed Tool** to quickly determine if a service or procedure requires prior authorization.

- Available at **Pre Auth Check**



PRIOR AUTHORIZATION REQUIREMENTS

PROCEDURES / SERVICES THAT NEED PRIOR AUTHORIZATION INCLUDE*:

- Potentially cosmetic
- Experimental or investigational
- High-tech imaging (e.g. CT, MRI, PET)
- Infertility
- Obstetrical ultrasound
  - One allowed in a 9-month period, any additional will require prior authorization except those rendered by perinatologists.
  - For urgent/emergent ultrasounds, treat using best clinical judgment and this will be reviewed retrospectively.
- Pain management

**This list is not all-inclusive. Use the Pre-Auth Needed Tool to check if a specific service or procedure requires prior authorization.*

PRIOR AUTHORIZATION REQUIREMENTS

INPATIENT AUTHORIZATION IS NEEDED FOR THE FOLLOWING*:

- All elective/scheduled admission notifications requested at least 5 days prior to the scheduled date of admit including:
  - All services performed in out-of-network facilities
  - Behavioral health/substance use
  - Hospice care
  - Rehabilitation facilities
  - Transplants, including evaluation
- Observation stays 23 hours require Inpatient Authorization
- Urgent/Emergent Admissions
- Within 1 day following the date of admission
- Newborn deliveries must include birth outcomes
- Partial Inpatient, PRTF and/or Intensive Outpatient Programs (IOP)

**This list is not all-inclusive. Use the Pre-Auth Needed Tool to check if a specific service or procedure requires prior authorization*

PRIOR AUTHORIZATION REQUIREMENTS

ANCILLARY SERVICES THAT NEED PRIOR AUTHORIZATION INCLUDE*:

- Air ambulance transport (non-emergent fixed-wing airplane)
- Durable medical equipment (DME)
- Home health care services including, home infusion, skilled nursing, and therapy:
  - Home health services
  - Private duty nursing
  - Adult medical day care
  - Hospice
  - Furnished medical supplies & DME

**This list is not all-inclusive. Use the Pre-Auth Needed Tool to check if a specific service or procedure requires prior authorization.*

PRIOR AUTHORIZATION TIMEFRAMES

Service Type	Timeframe
Scheduled admissions	Prior Authorization required five (5) business days prior to the scheduled admission date
Elective outpatient services	Prior Authorization required five (5) business days prior to the elective outpatient admission date
Emergent inpatient admissions	Notification within one (1) business day
Observation – 48 hours or less	Notification within one (1) business day for non-participating providers
Observation – greater than 48 hours	Requires inpatient prior authorization within one (1) business day
Emergency room and post stabilization, urgent care and crisis intervention	Notification within one (1) business day
Maternity admissions	Notification within one (1) business day
Newborn admissions	Notification within one (1) business day
Neonatal Intensive Care Unit (NICU) admissions	Notification within one (1) business day
Outpatient Dialysis	Notification within one (1) business day

UTILIZATION DETERMINATION TIMEFRAMES

Type	Timeframe
Prospective/Urgent	Three (3) calendar days
Prospective/Non-Urgent	Fourteen (14) calendar days
Emergency services	60 minutes (1 hour)
Concurrent/Urgent	Twenty-four (24) hours (1 calendar day)
Retrospective	Thirty (30) calendar days

CORRECT CODING FOR PRIOR AUTHORIZATION

PRIOR AUTHORIZATION WILL BE GRANTED AT THE CPT CODE LEVEL

- If a claim is submitted that contains CPT codes that were not authorized, the services will be denied.

- If additional procedures are performed during the procedure, the provider **must** contact the health plan to update the authorization in order to avoid a claim denial.

- It is recommended that this be done within 72 hours of the procedure. However, it **must** be done prior to claim submission or the claim will deny.

- Ambetter will update authorizations but will **not** retro-authorize services.
  - The claim will deny for lack of authorization.
  - If there are extenuating circumstances that led to the lack of authorization, the claim may be appealed.

CLAIMS, BILLING AND PAYMENTS

CLAIMS

WHAT IS A CLEAN CLAIM?

- A claim that is received for adjudication in a nationally accepted format in compliance with standard coding guidelines and does not have any defect, impropriety, lack of any required documentation or a particular circumstance requiring special treatment that prevents timely payment

ARE THERE ANY EXCEPTIONS?

- A claim for which fraud is suspected
- A claim for which a third-party resource should be responsible

HOW TO SUBMIT A CLAIM

THE TIMELY FILING DEADLINE FOR INITIAL CLAIMS IS 180 DAYS FROM THE DATE OF SERVICE OR DATE OF PRIMARY PAYMENT WHEN AMBETTER IS SECONDARY.

CLAIMS MAY BE SUBMITTED IN 3 WAYS:

1. **The Secure Provider Portal**
   https://www.buckeyehealthplan.com/providers.html

2. **Electronic Clearinghouse**
   - Payor ID 68069
   - Clearinghouses currently utilized by Ambetter will continue to be utilized
   - For a listing of clearinghouses, please visit our secure provider portal at the link above.

3. **Mail**
   P.O. Box 5010
   Farmington, MO 64640-5010

CLAIM RECONSIDERATIONS AND DISPUTES

CLAIM RECONSIDERATIONS

- For reconsideration requests, Providers can use the **Reconsider Claim** button on the Claim Details screen within the portal
- A written request from a provider about a disagreement in the manner in which a claim was processed. No specific form is required.
- Must be submitted within 180 days of the Explanation of Payment.

Mail claim reconsiderations to:

P.O. Box 5010
Farmington, MO 63640-5010

CLAIM DISPUTES

- Must be submitted within 180 days of the Explanation of Payment
- A Claim Dispute form can be found on our website at Ambetter.BuckeyeHealthPlan.com
- Mail completed Claim Dispute form to:

P.O Box 5000
Farmington, MO 63640-5000

CLAIM SUBMISSION – SUSPENDED STATUS

WHAT IF A MEMBER IS IN SUSPENDED STATUS?

- A provision of the ACA allows members who are receiving Advanced Premium Tax Credits (APTCs) a 3-month grace period for paying claims
- After the first 30 days, the member is placed in a suspended status. The Explanation of Payment will indicate LZ Pend: Non-Payment of Premium
- While the member is in a suspended status, claims will be pended
- When the premium is paid by the member, the claims will be released and adjudicated
- If the member does not pay the premium, the claims will be released, and the provider may bill the member directly for services

CLAIM SUBMISSION – SUSPENDED STATUS

EXAMPLE TIMELINE OF MEMBER IN SUSPENDED STATUS

- **January 1st**
  Member pays premium
- **February 1st**
  Premium due – member does not pay
- **March 1st**
  Member placed in suspended status
- **April 1st**
  Member remains in suspended status
- **May 1st**
  If premium remains unpaid, member is terminated. Provider may bill member directly for services rendered.

Claims for members in a suspended status are not considered "clean claims".

OTHER HELPFUL INFORMATION ABOUT CLAIMS

MAKE SURE TO INCLUDE THE RENDERING TAXONOMY CODE!

- Claims **must** be submitted with the rendering provider's taxonomy code
- The claim will deny if the taxonomy code is not present
- This is necessary in order to accurately adjudicate the claim

AND DON'T FORGET THE CLIA NUMBER!

- If the claim contains CLIA-certified or CLIA-waived services, the CLIA number **must** be entered in **Box 23** of a paper claim form or in the appropriate loop for EDI claims
- Claims will be rejected if the CLIA number is not on the claim

BILLING THE MEMBER

COPAYS, CO-INSURANCE AND DEDUCTIBLES

- Copays, co-insurance and any unpaid portion of the deductible may be collected at the time of service

- Deductible information, including the amount that has been paid toward the deductible so far, can be accessed via the Secure Provider Portal at **https://www.buckeyehealthplan.com/providers.html**

- If the amount collected from the member is higher than the actual amount owed upon claim adjudication, the provider must reimburse the member within 45 days

CLAIMS PAYMENTS: ELECTRONIC FUNDS TRANSFER

PAYSPAN®: A FASTER, EASIER WAY TO GET PAID

- Ambetter offers PaySpan® Health, a free solution that helps providers transition into electronic payments and automatic reconciliation
- If you currently utilize PaySpan®, you will need to register specifically for Ambetter
- **Set up your PaySpan® account:**
  - Visit www.payspanhealth.com and click Register
  - You may need your National Provider Identifier (NPI) and Provider Tax ID Number (TIN) or Employer Identification Number (EIN)

COMPLAINTS, GRIEVANCES AND APPEALS

COMPLAINTS, GRIEVANCES AND APPEALS

CLAIMS

- A provider must exhaust the claims reconsideration and claims dispute process before filing a complaint/grievance or appeal

COMPLAINT/GRIEVANCE

- Must be filed within 30 days of the Notice of Action
- Upon receipt of complete information to evaluate the request, Ambetter will provide a written response within 30 days

COMPLAINTS, GRIEVANCES AND APPEALS

APPEALS

- For Claims, the Claims Reconsideration, Claims Dispute and Complaint/Grievances process must be exhausted prior to filing an appeal

MEDICAL NECESSITY

- Must be filed within 30 days from the Notice of Action
- Ambetter shall acknowledge receipt within 10 business days of receiving the appeal
- Ambetter shall resolve each appeal and provide written notice as expeditiously as the member's health condition requires but not to exceed 30 days
- Expedited appeals may be filed if the time expended in a standard appeal could seriously jeopardize the member's life or health. The timeframe for a decision for an expedited appeal will not exceed 72 hours

COMPLAINTS, GRIEVANCES AND APPEALS

MEMBER REPRESENTATIVES

- Members may designate a provider to act as their representative for filing appeals related to medical necessity
    - Ambetter requires that this designation by the member be made in writing and provided to Ambetter
- No punitive action will be taken against a provider by Ambetter for acting as a member's representative

NEED MORE INFORMATION?

- Full details of the claim reconsideration, claim dispute, complaints/grievances and appeals processes can be found in our Provider Manual, located on our website at **ambetter.buckeyehealthplan.com**

SPECIALTY SERVICES & VENDORS

OUR SPECIALTY COMPANIES AND VENDORS

Service	Specialty Company/Vendor	Contact Information
High Tech Imaging Services	National Imaging Associates	844-265-1278 www.radmd.com
Vision Services	Envolve Vision©	1-800-334-3937 www.envolvevision.com
Dental Services	Envolve Dental©	www.envolvedental.com
Pharmacy Services	Pharmacy Services	1-866-399-0928 (Phone) 1-866-399-0929 (Fax)

QUESTIONS?