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New Contract Updates Provider Network

8/30/2019

Outline

- Overview
- NH State Medicaid Contract
- Revised Access Standards
- Provider Portal – Provider Analytic Tools
- Reminders/Provider Toolkit

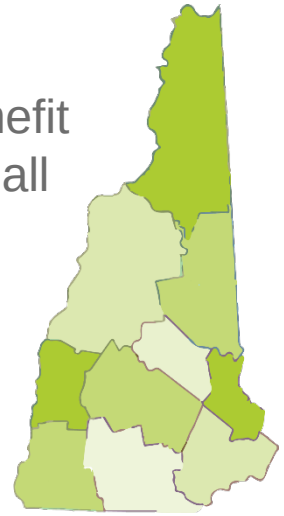
Overview

NH Healthy Families Current Snapshot

Providing Medicaid benefit coverage in all

10

counties



Contracted for Medicaid services with every hospital, FQHC, RHC, and community mental health centers including thousands of providers in NH and over the borders

Over 200

employees located in NH

Currently serving **Medicaid, Health Protection Program, Premium Assistance Program** and **Exchange Program** populations

Membership Exceeds

93,000

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82,000

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11,000

(As of 2/18/19)

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NH State Medicaid Contract Update

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Changes Take Effect: September 1, 2019

Contract Updates Continued

Claims

- Medicare Part A&B crossover claims billed on the UB-04 as secondary with dates of service September 1, 2019, and after will be reimbursed at the member's responsibility regardless of the Medicaid allowed amount.

- Timely Filing Change – The new deadline for filing claims is 120 days.

Contract Updates Continued

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Grievances and Appeals

Provider Appeals

- Must submit a written request for a claim appeal, along with documentation, within 30 calendar days of receiving the EOP, which serves as a Notice of Action.
- Provider will receive a confirmation of receipt of appeal in writing.
- Peer-to-peer review support, with a like clinician, will be provided upon request, prior to the appeal decision
- Appeals will be resolved through written notice within 30 calendar days of receipt.
- Provider has a right to request a State Fair Hearing if the adverse action is upheld.

Contract Updates Continued

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Grievances and Appeals

Member Grievances:

- A member grievance resolution may be extended up to 14 calendar days upon member request, or if additional information is needed.

Member Appeals

- Oral appeal requests will be handled as appeals and a written acknowledgement will be sent.
- A provider, acting as an authorized representative cannot request a member's continuation of benefits pending appeal even with the member's written consent.
- Peer-to-peer review support, with a like clinician, will be provided upon request from a member's provider prior to the appeal decision.
- A reasonable effort to give the member prompt oral notice of an expedited appeal resolution extension will be made.

Contract Updates Continued

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Care Management

- All members will be asked to complete a new Health Risk Screening tool. Results will be available in the provider portal within 7 days of completion.

- Members in care management will require collaboration from a member's PCP and providers for care plan development. Care plans will be available on the provider portal within 24 hours of completion.

- All members will be supported in arranging a wellness visit with their PCP after their Health Risk Screening. This visit should include screenings for physical and behavioral health conditions, depression, mood, suicidality, and substance use disorders.

Contract Updates Continued

Behavioral Health/SUD

- Pediatric providers will be required to complete Ages and Stages Questionnaires including PHQ and SBIRT.
- Providers/Programs must actively support Peer Recover Programs.
- Members with ACT services team need to be seen within 24 hours of being discharged from NH Hospital.
- All members must receive clinical evaluations within 3 business days of admission.
- Providers must complete a plan of safe care in collaboration with NHHF and the family/caregivers.
- If NHHF is unable to make contact with a member related to SUD within 3 business days, we will request the treating provider to make contact with the member within 24 hours.
- NHHF will be offering educational courses related to BH and SUD!

Contract Updates Continued

Pharmacy

- Uniform Preferred Drug List (PDL) which aligns with DHHS and other MCOs is being developed.

Revised Access Standards

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Primary Care: The bolded standards are as of September 1, 2019

- Urgent Care – within 48 hours of the Enrollee's request.
- Non-urgent, Symptomatic Care – within 10 days of the Enrollee's request.
- Non-Symptomatic Care – within 45 calendar days of the Enrollee's request.
- **Transitional Health Care – within 2 business days of a member's discharge from inpatient care.**
- After Hours Care - Acceptable care being: 24 Hour Answering Service, On-Call Physician, or Referral to Emergency Room.

Revised Access Standards Continued

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Specialty Care: The bolded standards are a of September 1, 2019

- After- Hours Care – Acceptable care being: 24 Hour Answering Service, On-Call Physician, or Referral to Emergency Room.
- Urgent Care – within 48 hours of the Enrollee's request.
- Non-Urgent, Symptomatic Care – within 10 calendar days of the Enrollee's request for specialist care and 10 business days for behavioral health care
- Non-Symptomatic Care – within 45 calendar days of the Enrollee's request.
- **Transitional Health Care – within 2 business days of a member's discharge from inpatient care; when ordered as a part of discharge planning.**
- **Transitional Home Care – within 2 calendar days of a member's discharge from inpatient care; when ordered by a physician or a part of discharge planning.**

Revised Access Standards Continued

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Mental Health Care: Revised Access Standards Effective September 1, 2019

- After- Hours Care – Acceptable care being: 24 Hour Answering Service, On-Call Physician, or Referral to Emergency Room.
- Urgent Care – within 48 hours of the Enrollee's request.
- **Non-Symptomatic Care – within 10 business days of the Enrollee's request.**
- Behavioral Health Non-Life Threatening Emergency – within 6 hours of the Enrollee's request.
- **Transitional Health Care – within 2 business days of a member's discharge from inpatient care; when ordered as a part of discharge planning.**
- **Aftercare appointments following a psychiatric discharge from hospital – within 7 calendar days of discharge.**

Revised Access Standards Continued

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Substance Use Disorder Care: Revised Access Standards Effective September 1, 2019

- After- Hours Care – Acceptable care being: 24 Hour Answering Service, On-Call Physician, or Referral to Emergency Room.
- Aftercare appointments following a psychiatric discharge from hospital – within 7 calendar days of discharge.
- Respond to Inquiries for SUD services – within 2 business days of the Enrollee or agencies request.
- Conduct initial eligibility screening for SUD services – within 2 business days of initial contact with Enrollee.
- Members who have screened positive for SUD shall receive an ASAM Level of Care.
- Assessment - within 2 business days from request or 3 business days after admission.

Revised Access Standards Continued

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Substance Use Disorder Care: Revised Access Standards Effective September 1, 2019

- Members identified for withdrawal management, outpatient or intensive outpatient services receive care - within 7 business days from date ASAM Level of Care assessment was completed.
- Members identified for partial hospitalization or rehabilitative residential services shall start receiving interim services that are identified - 7 business days from the date the ASAM Level of Care Assessment was completed and start receiving the identified level of care no later than 14 business days from the data the ASAM Level of Care Assessment was completed.
- care assessment, or identify alternatives or interim services until appropriate level of care is available.

Revised Access Standards Continued

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Substance Use Disorder Care: Revised Access Standards Effective September 1, 2019

- If the type of service identified in the ASAM Level of Care Assessment is not available from the provider that conducted the initial assessment within 48 hours, the provider shall provide interim SUD services and or make an appropriate closed loop referral to continue treatment until the member is accepted and starts receiving services by the receiving agency - 14 business days from initial contact.
- Pregnant women admitted to identified level of care - within 24 hours of ASAM level of care assessment, or identify alternatives or interim services until appropriate level of care is available.

Provider Portal Analytic Tools

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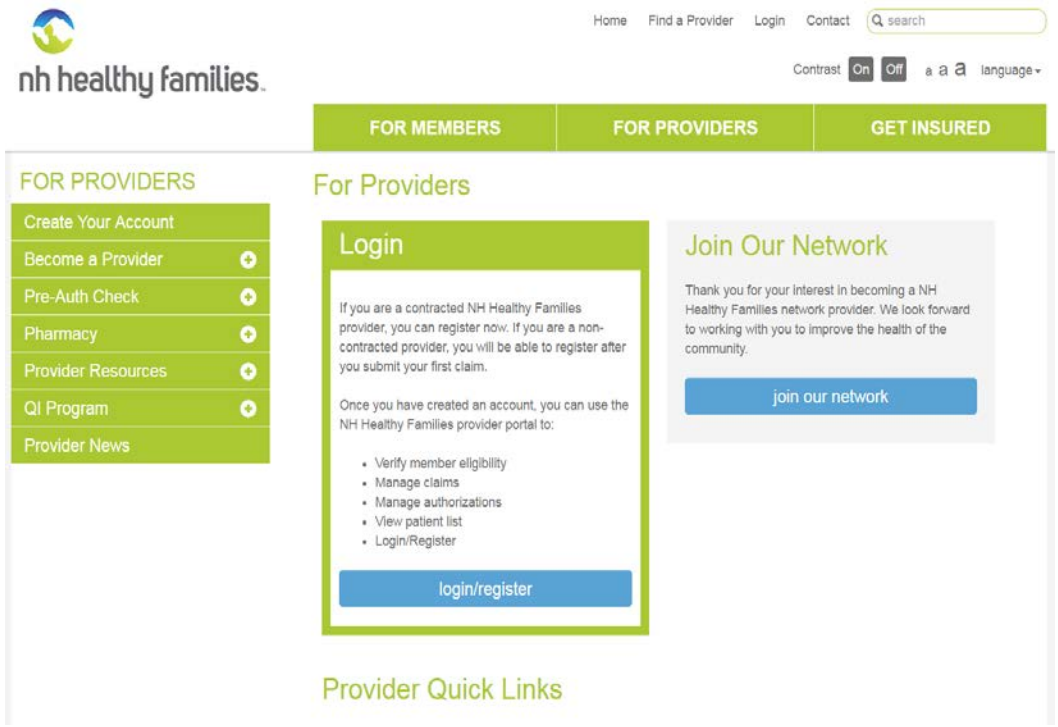
Changes Coming 2019

Ability to:

- 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

Provider 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

Provider Analytics Tool

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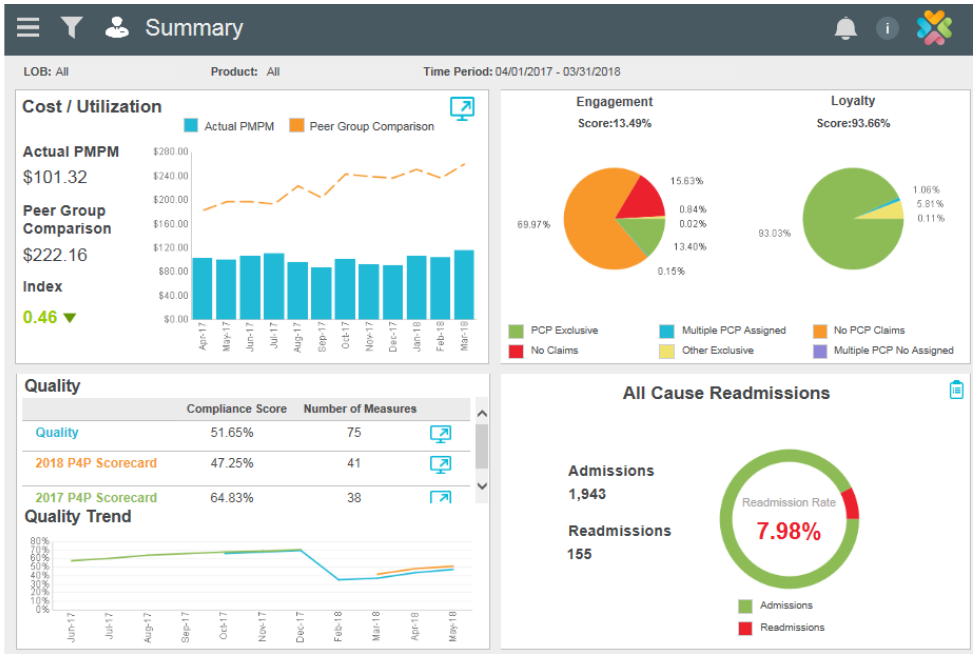
Your Pay-for-Performance, Cost and Utilization Reporting Tool

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.

Provider/Patient Tools Comparison

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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.

Provider Toolkit

Questions

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- Questions?
- Comments?
- Suggestions?

Thank You!