



Good Morning and Welcome to **Advantage by SHP** (HMO SNP) Provider Presentation

Please be sure to call in to our teleconference portion in order to hear the presentation.

- ❖ **Toll Free Call In Number: 1-866-724-6903**
- ❖ **Event Access Code: 696 873 1**

We will begin the presentation at 12:00PM

ADVANTAGE BY SUPERIOR HEALTHPLAN (HMO SNP)

A SPECIAL NEEDS PLAN (SNP) COMMITTED TO QUALITY CARE

Provider Overview

Introductions & Agenda

- Your Presenters
- Eligibility Verification
- Medical Management/Authorizations
- Member Services
- Provider Relations/Provider Services
- Website www.superiorhealthplan.com
- Advantage by Superior Health Plan
- Model of Care

About Us

- 425,000+ Members statewide
- 7 programs – STAR, STAR+PLUS, STAR Health (Foster Care), CHIP, CHIP RSA (formerly EPO), CHIP Perinate and Medicare Advantage
- Began serving Texas in 1998
- 7 locations throughout Texas as of 2008
- Subsidiary of Centene Corporation
(www.centene.com)

Verify Eligibility

- Advantage by Superior HealthPlan ID Card
- CMS Website
- Contact Member Services: 1-866-516-4501

Advantage ID Card (sample)



Part D Plan: US Script
Rx Bind#: 008019
Rx GRP: 9802



Name:

Sample

Member ID#:

Effective Date:

DOB:

PCP Name:

PCP Phone #:

If you have an emergency, call 911 or go to the NEAREST emergency room (ER). You do not have to contact Advantage by Superior HealthPlan for an okay before you get emergency services. If you are not sure whether you need to go to the ER, call your PCP or NurseWise toll-free at 1-866-516-4501, option 7, or TTY at 1-877-248-1744. NurseWise is open 24 hours per day.

CMS H5294_001

MEMBER SERVICES

1-866-516-4501
TTY: 1-877-248-1744
Mon-Sun, 8 a.m. - 8 p.m.



PROVIDERS This card does not guarantee eligibility or authorization. For eligibility, call Superior at 1-866-516-4501 or NurseWise at 1-800-783-5386, option 7. For prior authorization and case management referral, call 1-800-218-7508. For questions, pharmacists can call 1-800-460-8988. For pharmacy prior authorization, call 1-866-399-0928.

Non-participating providers must have all services prior authorized through Superior except for emergency services or services that are self-referred. Please call Superior at 1-866-516-4501 for more information on services that are self-referred.

Claims submissions:

Advantage by Superior HealthPlan
P.O. Box 3000
Farmington, MO 63640-3822

Sample

Primary Care Physicians (PCPs)

- Advantage by SHP members are required to select a primary care provider from the Advantage Provider Network
- Members do not have to select a PCP at time of enrollment, but are encouraged to do so
- PCPs will treat most of the routine healthcare needs
- PCPs are responsible for initiating prior authorizations for hospital admission and referrals/authorization to specialists.
- Members selecting or changing PCP's can call Member Services (1-866-516-4501), and a new ID card will be issued in approximately 1 to 2 weeks.

Medical Management: Referrals/Authorizations

- Referral is required when medically necessary care is needed beyond PCP scope
- PCP must initiate the referral
- Specialist may **NOT** refer to another Specialist (only via PCP)
- All non-par providers will require prior authorization

Medical Management: Obtaining an Authorization

- Listing of procedures that require authorization are found on our website and in the provider manual
- Authorization should be initiated at least 5 days in advance for non emergent services
- Fax or Call In Authorization Requests:
 - Use the Request for Authorization Form found on the web site to fax in to 1-800-690-7030
 - Call Medical Management at 1-800-218-7508
- Provide referral specialist with demographics, diagnosis, clinical information for medical necessity and dates of service

Authorizations: MRI-CT SCAN-PET SCAN

Effective August 2, 2010 an authorization will be required for MRI-CT SCAN-PET SCANS

- National Imaging Associates (NIA) has been selected by SHP to administer the program
- The servicing provider (PCP or Specialist) will be responsible for obtaining authorization for the procedures by:
 - Accessing the Radmd.com web site
 - Utilizing the toll free number
- Servicing providers and imaging facilities may access status of authorizations using a tracking number by:
 - Accessing Radmd.com
 - Accessing IVR (Integrated Voice Response) through a toll free number
- Inpatient, ER procedures will not require authorization
- All other radiology procedures will not require authorization
- All claims for these services should continue to be submitted to SHP

Medical Management: Denials

- When medical necessity cannot be established, a peer to peer conversation is offered
- Denial letters will be sent to member and Provider
- The clinical basis for the denial will be indicated
- Member appeal rights will be fully explained

Medical Management: Appeals

- **Contracted providers do not have appeal rights.** The corporate claims department reviews all contracted provider claims issues through the claim reconsideration process.
- **Non-contracted providers may request a standard reconsideration for purposes of obtaining payment only:**

Providers have 60 days from the date on the EOP to file a dispute. The provider would need to sign and submit a waiver of liability for the claim appeal to be considered.

Member Affairs

- **Connections Team and Member Advocates**
 - Assist provider with non-compliant members
 - Offer member education on program benefits
 - Coordinate assistance for members with socio-economics issues (food pantry, utility bills, etc)
 - Assist with transportation needs for members
 - 100% bi-lingual staff in English/Spanish

Utilize your member advocate for any member-related issues by calling 1-866-516-4501

Provider Relations

- Provider Relations is Responsible for Provider Orientations and Education:
 - New Billing Requirements
 - New Products, Programs or Processes
- Provider Relations now offers online webinar trainings along with local group training sessions
 - Calendar is listed under “Events” on our web site, www.superiorhealthplan.com
- Provider Relations also serves as liaisons for claims-related issues or concerns

Provider Services

Provider Services handles the following:

- Claims status
- Claims payment questions
- Instructions on how to complete claims
- Billing questions

Provider Services Department

1-877-391-5921, option 3

Provider Network Contracting and Implementation

- The Network Development & Contracting department is a centralized dedicated team that handles all contracting for new and existing providers to include:
 - New provider contracts
 - Adding providers to existing Superior contracts
 - Adding additional products (i.e. CHIP, Foster Care, Advantage by SHP) to existing Superior contracts
 - Checking status of submission of any contract requests

Contract Packets can be requested via the following:

- Website: www.superiorhealthplan.com, select link “Click here for more information on becoming a Superior provider” and follow instructions
- Phone: 877-391-5923 x 22534

Superior HealthPlan Web Site

www.superiorhealthplan.com

- View Provider Directory
- Advantage by SuperiorHealthPlan Evidence of Coverage (EOC)
- Advantage by SuperiorHealthPlan benefits and formulary
- Links for additional Provider Resources

Superior HealthPlan Web Site: Provider Tab

The screenshot shows the Superior HealthPlan website's Provider Tab. The navigation menu includes 'About Us', 'Find a Doctor', 'Stay Healthy', 'Members', 'Providers', and 'Medicare Advantage'. The 'Providers' tab is selected. The main content area is titled 'PROVIDERS' and includes a 'Provider Survey' section. A sidebar on the left lists 'Resources' such as 'Become a Provider', 'Electronic Transactions', 'Health Passport', 'Primary Care Update', 'QAPI Program', 'Training Documents', and 'Resources'. The main content area contains text about provider services, including information on NIA utilization management and prior authorization. There are also links for 'Become a Provider', 'Electronic Transactions', 'Login', and 'Register'. A 'Provider Manual' section is also visible, listing various manuals and attachments.

Callout arrows point to the following sections:

- Provider Tab**: Points to the 'Providers' link in the navigation menu.
- Advantage Tab**: Points to the 'Medicare Advantage' link in the navigation menu.
- Contact Info**: Points to the 'Provider Services' section, which includes the phone number (877) 391-5923 and office hours.
- Manual**: Points to the 'Provider Manual' section, which lists various manuals and attachments.
- Resources**: Points to the 'Resources' link in the sidebar.
- Become a provider**: Points to the 'Become a Provider' link in the sidebar.

To become a provider for SHP or to add a product to your current SHP contract, please go to our web site under the "Provider" tab and click on the links indicated to the left to print out a Contract Request Form. Please fax or email the completed form to Network Development, or call 877-391-5923 x22534 for assistance.

Also on the main provider screen is a link to resources which includes forms, and a link to our provider manuals, as well as general contact info, and our secure login.

Network Development

Phone: 877-391-5923 x 22534 * Fax: (866) 224-3339

Email: SHP-NetworkDevelopment@centene.com

Superior HealthPlan Web Site: Advantage by Superior HealthPlan (HMO SNP)

The screenshot shows the Medicare Advantage by Superior HealthPlan website. The page features the 'ADVANTAGE by Superior HealthPlan HMO SNP' logo and a 'SUPERIOR HealthPlan' logo. A banner image shows a smiling woman with the word 'MEDICARE' overlaid. The main content area includes a 'Medicare Home' section with a list of links: General Medicare Information, Enrollment Applications and Instructions, Evidence of Coverage, Annual Notice Of Change, Summary of Benefits, Accessing Plan Benefits, Find a Provider or Pharmacy, Prescription Drug (Part D) Benefit Information, Low Income Subsidy Premium Benefit Information, CMS Plan Rating Information, Best Available Evidence, Problems or Complaints, and Notice of Privacy Practices. The 'Medicare' section provides an overview of the Advantage by Superior HealthPlan (HMO) as a Special Needs Medicare Advantage Plan serving dual eligible members in Bexar County, Texas. It lists benefits such as Part D prescription drug benefits, transportation to appointments, nurse services, and choice of doctors and pharmacies. It also provides contact information for the plan, including the address (8431 Fredericksburg Rd., Suite 340, San Antonio, TX 78229), phone numbers ((866) 516-4501 and (800) 735-2989), and member service hours (8:00AM to 8:00PM, 7 days a week). A 'Member Service Hours' section lists services like locating a primary care physician, Part C coverage information, and grievance/appeals information. Three blue callout boxes with arrows point to specific areas: 'Advantage Medicare Information' points to the left sidebar; 'Overview of our Advantage HMO SNP plan' points to the main Medicare text; 'Contact Info' points to the contact details; 'Member Services' points to the member service hours; and 'Grievance, Complaints & Appeals Info' points to the grievance/appeals section.

<http://medicare.superiorhealthplan.com/>

Superior HealthPlan Contact Information

- **Claims Status/Issues**
 - Provider Services 1-877-391-5921, option 3
- **Eligibility Verification**
 - Member Services 1-866-516-4501
- **Authorizations & Referrals**
 - Medical Management 1-800-218-7508
- **NurseWise 24-Hour Phone Line**
 - 1-800-783-5386

HIPAA & Fraud Waste and Abuse

- Health care fraud and abuse account for over \$100 billion, annually, in losses in the United States' healthcare industry.
- As part of the federal government's efforts to combat fraud and abuses, Congress passed the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Balanced Budget Act of 1997 (BBA)
- HIPAA includes a national healthcare fraud and abuse program that combines the efforts of the federal, state and local law enforcement. This includes a beneficiary incentive plan that offers a monetary award to beneficiaries who report suspected fraud and/or abuse.
- Superior HealthPlan is committed to fighting fraud, waste and abuse to safeguard the health and welfare of our clients.

Health Insurance Portability and Accountability Act (HIPAA)

- HIPAA aims to improve the efficiency and effectiveness of health information systems.
- HIPAA regulations establish transaction standards, minimum security requirements, minimum privacy protections for protected health information (PHI) and National Provider Numbers (NPIs)
- The Office for Civil Rights is responsible for implementing and enforcing the privacy regulations
- The Centers for Medicare & Medicaid Services (CMS) is responsible for implementing and enforcing other HIPAA regulations



Examples Fraud, Waste and Abuse Cases

- False Claim Act Violations
 - Pharmacies charging Part D members a higher rate than others for the same drug
 - Pharmacies billing for brand name drugs when generic drugs are provided to the member
 - Billing for non-covered services or for services the member did not receive
 - Ignoring billing discrepancies
- Billing for services and supplies not rendered, billing multiple payors or duplicate billing
- Upcoding and unbundling
- Provider kickbacks for member referrals
- Member forging prescriptions or using stolen ID number
- Physical, sexual or emotional abuse of a member



**ALL SUSPECTED FRAUD, WASTE AND ABUSE ISSUES
SHOULD BE REPORTED IMMEDIATELY**

Reporting Fraud, Waste or Abuse

- **Everyone is responsible for reporting suspected fraud, waste and abuse.**
- You can report to:
 - Medicare: 1-800-Medicare
 - OIG (Office of Inspector General): **1-800-436-6148**



Advantage by Superior HealthPlan (HMO)



Superior Medicare Advantage

Covered Eligibility Categories



- Must be eligible for Medicaid and Medicare Parts A & B
- Permanently reside in the service areas: Bexar County, and in 2011 Nueces County
- Individuals 65 or older, or Individuals at least 18 and under age 65 with certain disabilities

Special Needs Plans (SNP)

Medicare Special Needs Plans (SNP) are a type of Medicare Advantage Plan that generally limits membership to people with specific diseases or conditions. SNP's tailor their benefits, choose their providers and create their drug formularies to best meet the specific needs of the groups they serve. Individuals must meet at least one of the following criteria:

- Living in an institution such as a nursing home, long term care facility (Institutional SNP).
- Eligible for Medicare and Medicaid (Dual Eligible SNP).
- Have a chronic or disabling condition such as diabetes, congestive heart failure or COPD (Chronic Illness SNP).

Authorization/Referral Requirements

Certain services that require the members PCP to obtain prior authorization from the plan include:

Inpatient Facility Admissions

- All inpatient admissions including acute hospitalization, behavioral health, substance abuse, long term care, rehabilitation facilities, skilled nursing facilities and inpatient hospice
- Admissions following emergency room visits to an out of network hospital



Authorization/Referral Requirements (cont)

Outpatient Facility Care

- Outpatient or ambulatory surgery services
- Dialysis services at an out of network center (unless temporarily out of area)
- Rehabilitation services for cardiac, occupational, speech, physical or respiratory therapy
- Outpatient behavioral health testing and services
- Outpatient substance abuse

Home Health Services:

- Services are based in the home and include but are not limited to home nursing visits or private duty nursing or a home health aid
- Infusion Therapy
- Homemaker visit, social worker and supplies for home health care

Authorization/Referral Requirements (cont)

DME, Orthotics and Prosthetics

- All durable medical equipment over \$500 such as wheel chairs, hospital beds, C/bi-pap equipment and supplies
- Prosthetic devices and orthotics

Medical Services

- Podiatry
- Free standing diagnostic centers: for example, CT, MRI, MRA, PET scans and nuclear cardiology, etc.



Authorizations (cont)

- Any experimental or investigational procedure, service or drug protocol
- Pain management services

Transportation

For example, Scheduled Air Ambulance



For more information on Referrals and Authorizations, please contact Medical Management at 800-218-7508

Referrals/Authorizations: Self-Referral

Medicare Advantage members can self refer for the following services:

- Routine women's health care, including breast exams, mammograms, pap test, etc.
- Flu shots, pneumonia vaccinations (in network)
- Emergency services
- Urgent medical need
- Kidney dialysis at Medicare-certified dialysis center when temporarily out of the service area

Co-Pays, Deductibles & Premiums

Members must have full Medicaid benefits, as well as Medicare benefits, to join our plan.

- Medicare will pay the monthly plan premiums
- Medicaid will pay the monthly Part B premium
- Medicaid will pay the members annual deductible, co-pays and assist with prescription drug costs

**** Individuals without state help (Medicaid) will be liable for premiums, deductibles and co-pays ****

U.S. Script: Part D Drug Plan

- Drug Tiers
 - Tier 1 - Generic
 - Tier 2 - Preferred Brand Name
 - Tier 3 - Non-Preferred Brand Name
 - Tier 4 - Injectables (note: there can be generic injectables)
- Unlimited number of monthly prescriptions.
 - Includes a 30 day supply, or a 90 day supply of maintenance drugs, at either a retail pharmacy or via mail order
- Generic Drug Copays
 - 2010: \$1.10
 - 2011: starting January 2011 the copay will be \$0
- Brand name drugs, non-preferred drugs and non-generic injectables will have a copay from \$3.30 up to \$6.30 in 2010 and 2011.

U.S. Script: Categories not covered

Not all drugs are covered under Part D.

Certain drugs, such as some of the following, may be covered under Part B:

- Antigens
- Osteoporosis
- Erythropoietin
- Hemophila clotting factors
- Injectable drugs
- Immunosuppressive drugs
- Some oral cancer/oral anti-nausea drugs
- Inhalation and infusion drugs



U.S. Script: Categories not covered

By law, certain categories of drugs are not covered under Medicare Part B or Medicare Part D:

- Non-prescription (over the counter drugs)
- Drugs used to promote fertility
- Drugs used to relief cough or cold systems (over the counter)
- Drugs used for cosmetic purposes
- Drugs used to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations, when medically necessary
- Drugs used for the treatment of sexual or erectile dysfunction such as, Viagra, Cialis, Levitra and Caverjet
- Drugs used for treatment of anorexia, weight loss or weight gain
- Barbiturates and benzodiazepines (may be covered by medicaid/TMHP)

U.S. Script: Restrictions

Restrictions:

- **Prior Authorizations (PA)**- certain drugs the doctor prescribes will need plan approval prior to plan coverage. Without approval, the plan may not cover the drugs. Doctors can request a prior authorization form from U.S. Script by calling 1-800-460-8988 or by going on to the SHP web site.
- **Quantity Limits (QA)**- certain drugs have a limit on how many refills or the quantity of drugs refilled. For example, if it is considered safe to take one pill a day, we may limit coverage to no more than one pill per day or a 30 pills for a one month supply

U.S. Script: Transition Policy

Transition Policy

- New Advantage plan members can receive a one time 30 day refill for a non-formulary drug or a drug requiring an a prior authorization within their first 90 days of membership.
- This policy also applies to current members if any of their current drugs are placed on the excluded list beginning in January of the following year.
- The transition period allows the member and doctor to either change the drug to one on the formulary or to file an exception to have the drug covered.

U.S. Script: Contact Info

U.S. Script

Member Services

1-800-460-8988

Option #2 Medicare Part D

Option #4 Superior Advantage



Clinical Pharmacy Services:

Allows the provider to speak with a Pharmacy Tech,
Manager or Pharmacist at **1-866-399-0928**

Advantage: Member Value Adds

- **Unlimited Physicals per year with no co-pay**
- ***Over The Counter (OTC) Supplies**
 - \$25 monthly credit for OTC supplies such as band aids, vitamins, pepto- bismol, etc.
 - Supplies will be mailed to the members' residence at no cost or co-pay
- **24 Hour nurse line: 1-866-516-4501 Option #7**
- **Dental Services – Delta Dental 1-866-512-8304**
 - 2 Oral exams per year with no co-pay
 - 2 Cleanings per year with no co-pay
 - 2 Fluoride treatments per year with no co-pay
 - 1 Dental X-Ray per year with no co-pays
 - Additional \$500 in comprehensive dental benefits per year
- ****Vision Services - TotalVision 1-888-756-8768**
 - No cost or copay for routine vision services
 - 2010 & 2011: 1 Routine eye exam each year (2010 & 2011)
 - 2010: \$500 limit for exam, eyewear or contacts every year
 - 2011: \$200 limit for eyewear or contacts every 2 years

***OTC Supplies starting in Bexar & Nueces in 2011**

****Vision value add-ons vary for 2010 & 2011**

Advantage: Member Value Adds (cont)

- **Hearing Services****

Bexar County: Beltone 210-349-5999 or 210-533-1211

Bexar County: A/B Hearing 210-342-2299

- 2010: 2 hearing aids every 3 years, including replacement batteries and cords for hearing aids
- 2011: 1 hearing aid fitting yearly and \$1500 coverage limit for hearing aids every 2 years

- **Transportation Services****

Bexar County: ACCESS2CARE 1-866-606-9911 (24/7)

- 25 round trips per year to approved medical appointments with no co-pays
- Can either receive a ride or request mileage reimbursement at \$.36 per mile
- 4 business days advance notice of appointment is required
 - Transportation can be scheduled with less than a 4 day notice if the transportation provider can call the physician's office to verify it is an emergency and the member needs to be seen sooner

**Providers for these benefits in Nueces county will be announced at a later time.

Model of Care

**Advantage by Superior HealthPlan's
Model of Care Plan**

Model of Care: Individualized Care/Service Plan

As a Special Needs Plan for dual-eligibles, SHP is dedicated to gaining the members' participation in individualized care plan where the interdisciplinary team all work together to create a plan that will meet the specific needs of the member.

The interdisciplinary team is made up, but not limited to, the following:

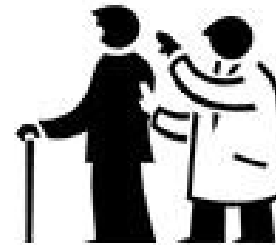
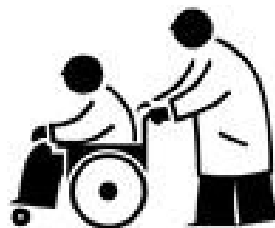
The member, caregiver, social support network, social worker, care manager, primary care physician, appropriate specialists, therapists, behavioral health providers, dietician, pharmacist, etc. The team also includes SHP departments such as Compliance, QI, Case Management, Service Coordination, Provider Relations, Network Development, etc.



Model of Care: What is is the plan?

Each individualized plan of care will:

- Describe the services that are to be provided to the member in order to reach their individually determined goal
- Describe any services the member has refused
- Describe the notification processes to providers and to beneficiaries when the plan alters due to changes in health of the member



Model of Care: Goal

The overarching goal of our Model of Care is to improve health outcomes for our members

- Ensure access to medical, behavioral health, and social services for our members
- Provide coordination and continuity of care
- To arrange for seamless transition of care across healthcare settings, providers, and health services
- Promote and ensure access to preventative healthcare services
- Provide access to the most appropriate and cost efficient health care services
- Monitor the over and underutilization of health care services
- Partner with the enrollee/caregiver to promote self-management, functional status and improved mobility

Interdisciplinary Care Team

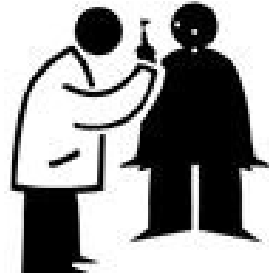
Team communication, collaboration and cooperation are the cornerstones for positive outcomes

- SHP is committed to assisting our providers to ensure that our members have the appropriate care and services that will increase the chance of an optimal outcome
- The team will work together and communicate with each other and with the member to develop and implement the care plan with focus on attaining & maintaining the individual member's physical, behavioral & psychosocial well-being
- The team will work together to coordinate services and share information, recognizing specialized knowledge and skills of all team members
- There will be care coordination and case review meetings on a regular basis as needed (either face-to-face or teleconference)

Model of Care: Success

Success Factors:

- Increased utilization of preventative health measures
- Prescription compliance
- Improved perception of health status
- Improved mobility and functional status
- Reduction of poly-pharmacy use
- Improved quality of life



Advantage by Superior HealthPlan

(HMO SNP)

Questions and Answers