AMBETTER OF ALABAMA

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 Engagement
  - Public Website and 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.

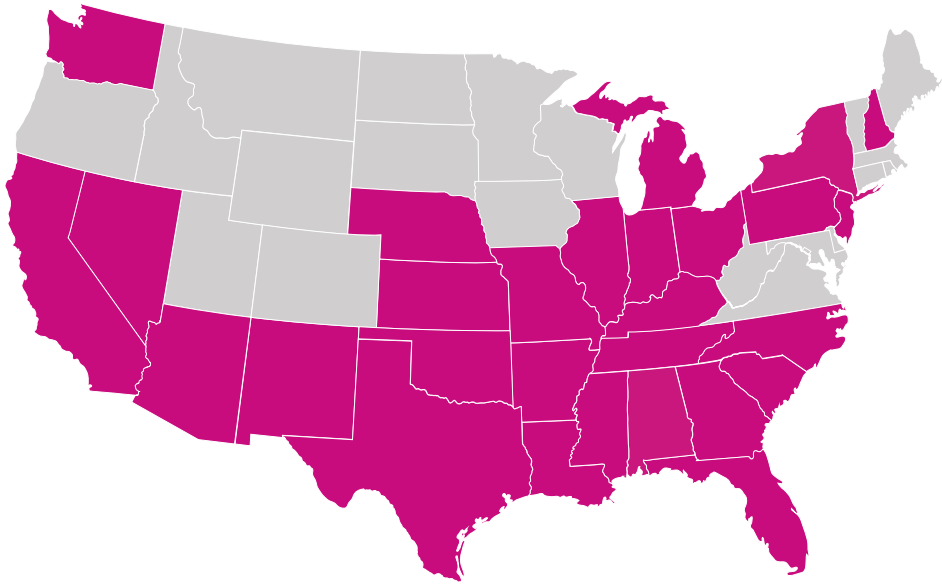
WE PROVIDE MARKET-LEADING, AFFORDABLE HEALTH INSURANCE ON THE MARKETPLACE.

#1 carrier
on the health insurance marketplace

2014
Year that Ambetter began

2.0M+
members insured

28
states

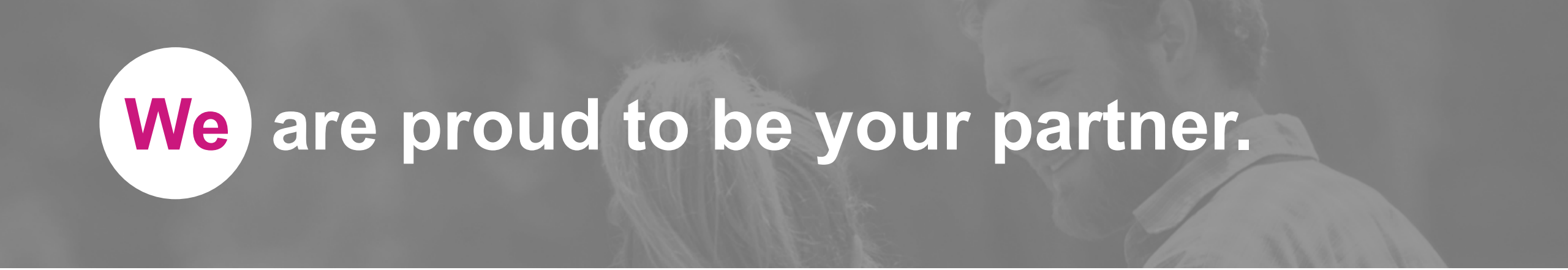


We target a focused demographic.

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 – – Alabama ***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.

SELECT*: This tailored network is built around exclusive agreements with health systems and their providers and supports Ambetter's lower-premium products. Referrals aren't required.

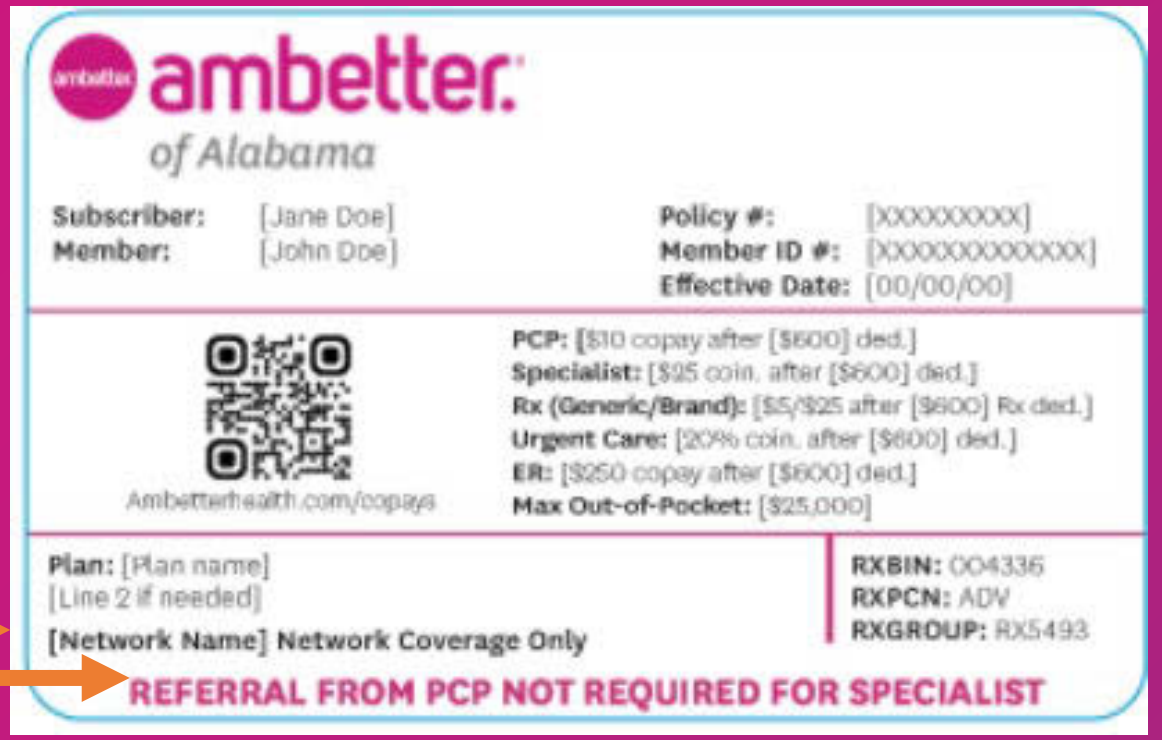
VALUE*: This tailored network of healthcare providers and hospitals supports Ambetter's lowest-premium product and has referral requirements for certain types of care.

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 Ambetter Plan the member has selected;
  - The Provider Network the member belongs to; and
  - Any referral requirements based on the member's plan selection.
- *NOTE: Presentation of a member ID card is not a guarantee of eligibility. Providers must always verify eligibility on the same day services are rendered.*



WHAT YOU NEED TO KNOW

GETTING ACQUAINTED

KEY CONTACT INFORMATION

Ambetter of Alabama

PHONE

1-800-442-1623

TTY/TDD

1-800-442-1623 (TTY 711)

WEB

https://www.ambetterofalabama.com

PORTAL

https://www.ambetterofalabama.com/provider-resources/login.html

THE PROVIDER MANUAL

THE PROVIDER MANUAL IS YOUR COMPREHENSIVE GUIDE TO DOING BUSINESS WITH AMBETTER OF ALABAMA.

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 of Alabama website at **https://www.ambetterofalabama.com**

PROVIDER ENGAGEMENT

- The **Ambetter of Alabama** Provider Services department includes trained Provider Engagement 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 of Alabama** Provider Services at **1-800-442-1623** providers will be able to access real time assistance for all their service needs

PROVIDER ENGAGEMENT

- As an **Ambetter of Alabama** provider, you will have a dedicated Provider Engagement Administrator available to assist you
- Our Provider Engagement Administrator serve as the primary liaisons between our health plan and provider network
- Your Provider Engagement Administrator 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 https://www.ambetterofalabama.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 https://www.ambetterofalabama.com
- Enrollments are effective thirty days from the date all clean documents are received.

Please send the following items to https://www.ambetterofalabama.com :

✓Contract Clarification

✓Demographic information updates

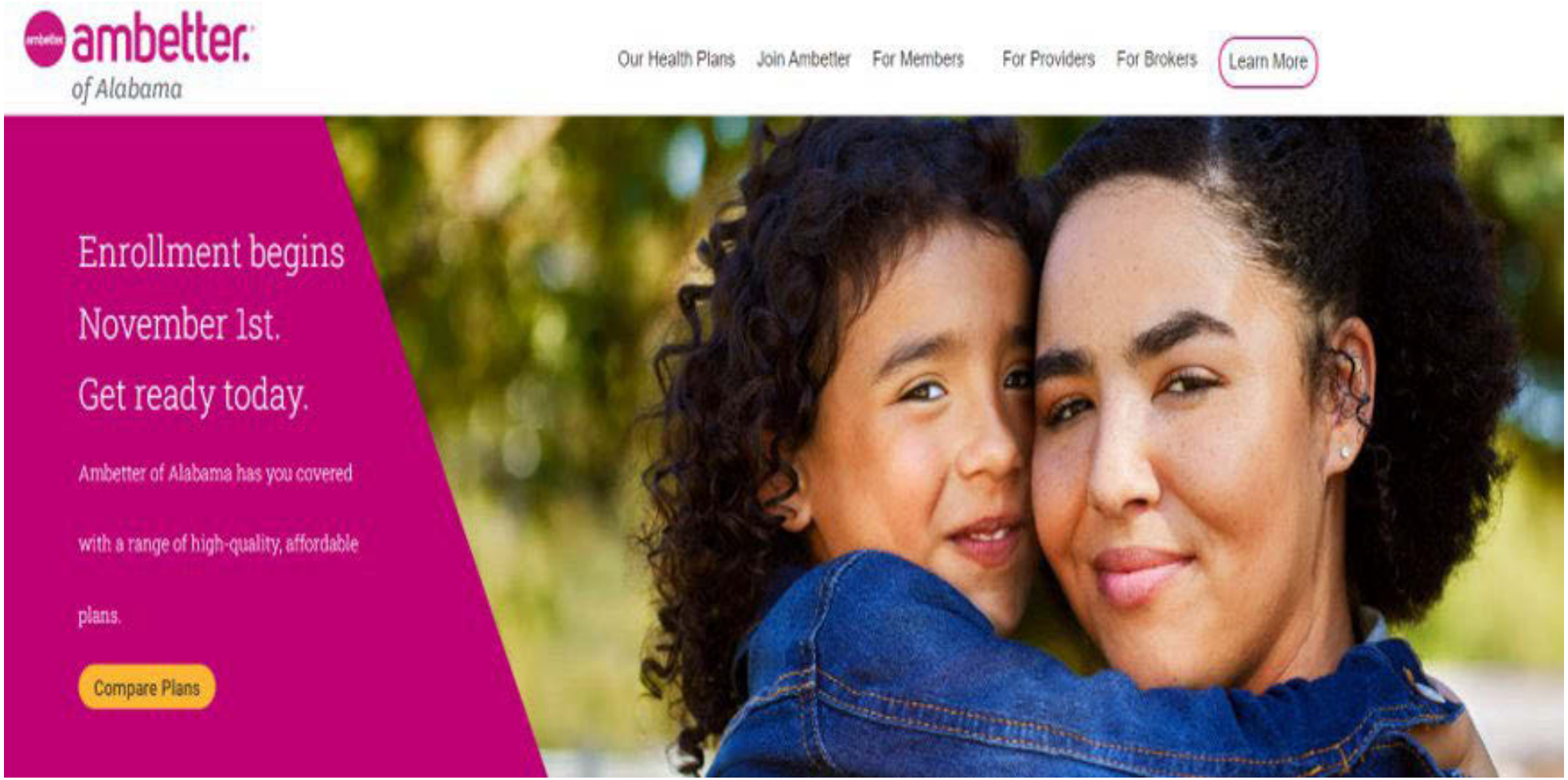
✓Initiate credentialing of a new practitioner

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

PUBLIC WEBSITE AND SECURE PORTAL

THE AMBETTER PUBLIC WEBSITE

https://www.ambetterofalabama.com



THE AMBETTER PUBLIC WEBSITE

WHAT'S ON THE PUBLIC WEBSITE?

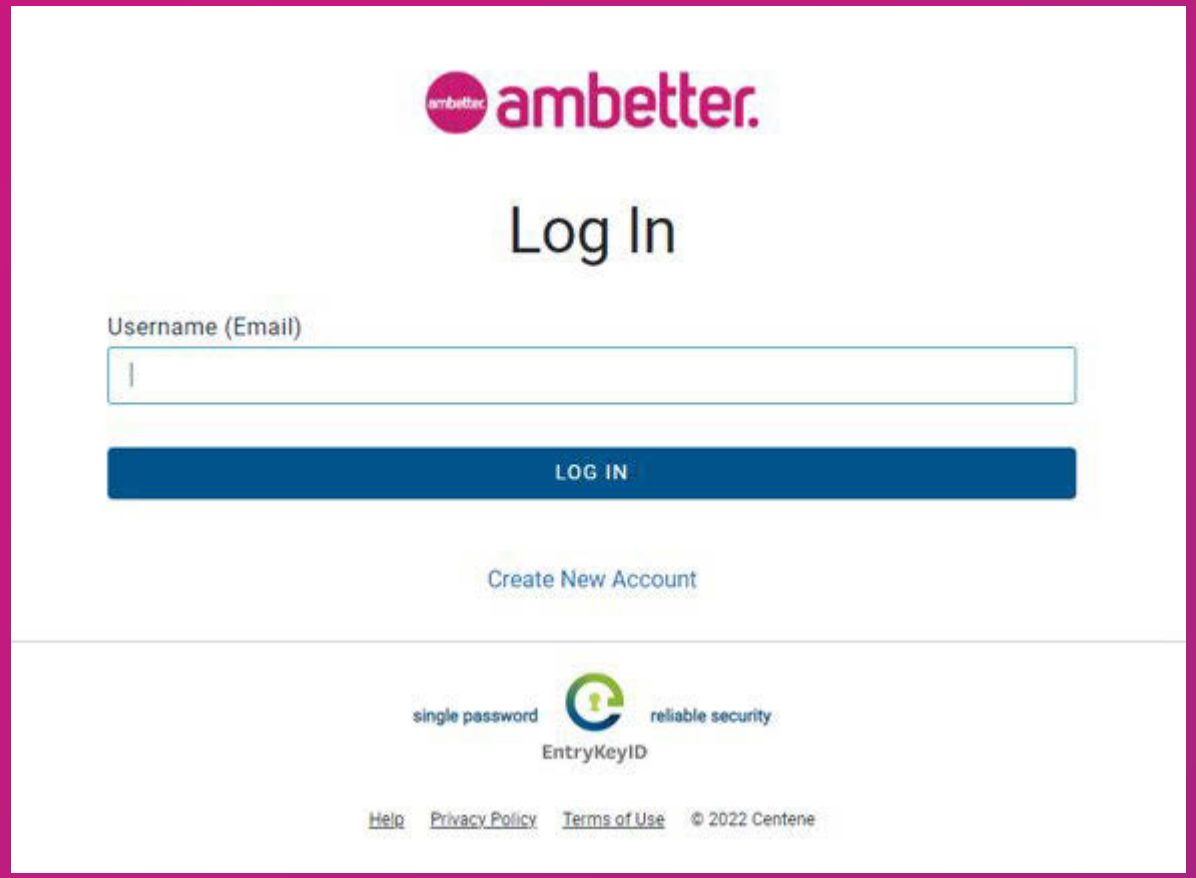
- The Provider Manual
- Quick Reference Guides
- Important Forms (Notification of Pregnancy, Prior Authorization Fax forms, etc.)
- The Pre-Auth Needed Tool
- The Pharmacy Preferred Drug Listing
- And much more!

SECURE PROVIDER PORTAL

https://www.ambetterofalabama.com

Registration is free and easy!

Contact your Provider Engagement Administrator 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

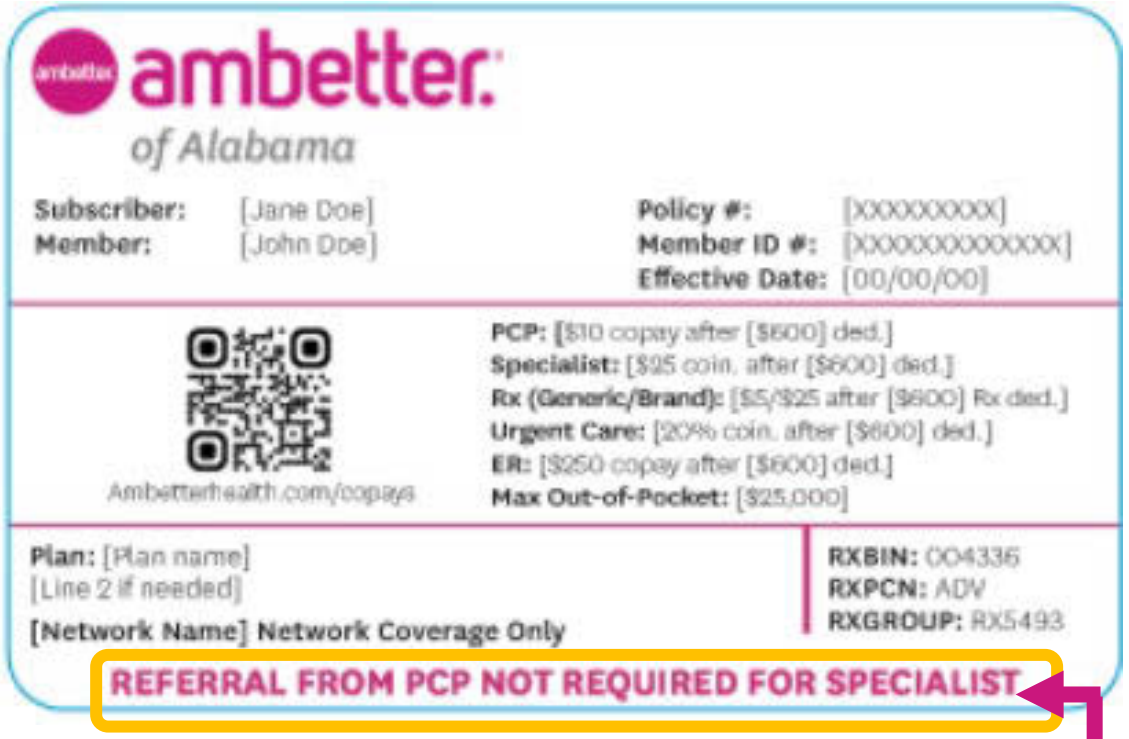
PCP reports available on **AMBETTEROFALABAMA.COM** secure provider portal are generated on a monthly basis and can be exported into a PDF or Excel format.

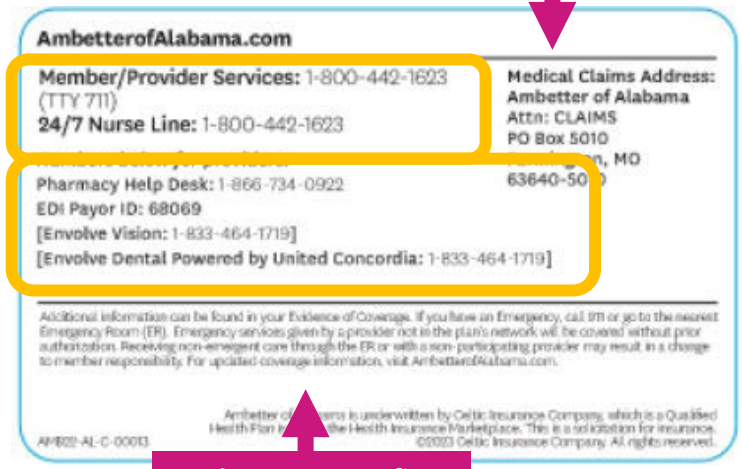
PCP REPORTS INCLUDE:

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

VERIFICATION OF ELIGIBILITY, BENEFITS AND COST SHARES

NAVIGATING THE MEMBER ID CARD





Plans can include:

- Ambetter Gold / Silver / Bronze
- SELECT
- VALUE
- Ambetter Virtual Access

Certain plans may have a referral requirement. Please note:

1. Referral from PCP is required to see a specialist. Auth may be required.
2. Referral from PCP is **not** required to see a specialist. Auth may be required.

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
- PCPs can still administer service if the member is not on their panel and they wish to have member assigned to them for future care

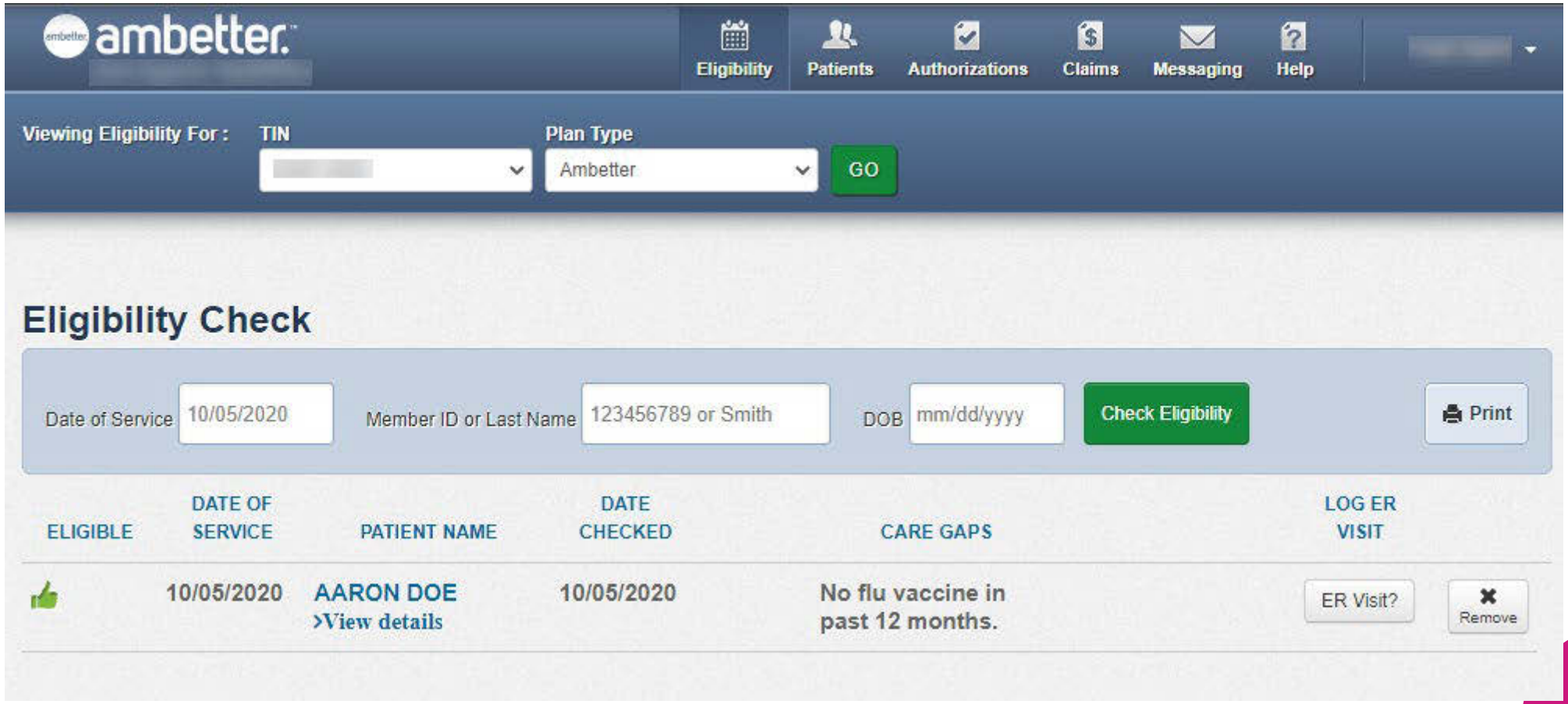
VERIFICATION OF ELIGIBILITY, BENEFITS AND COST SHARE

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

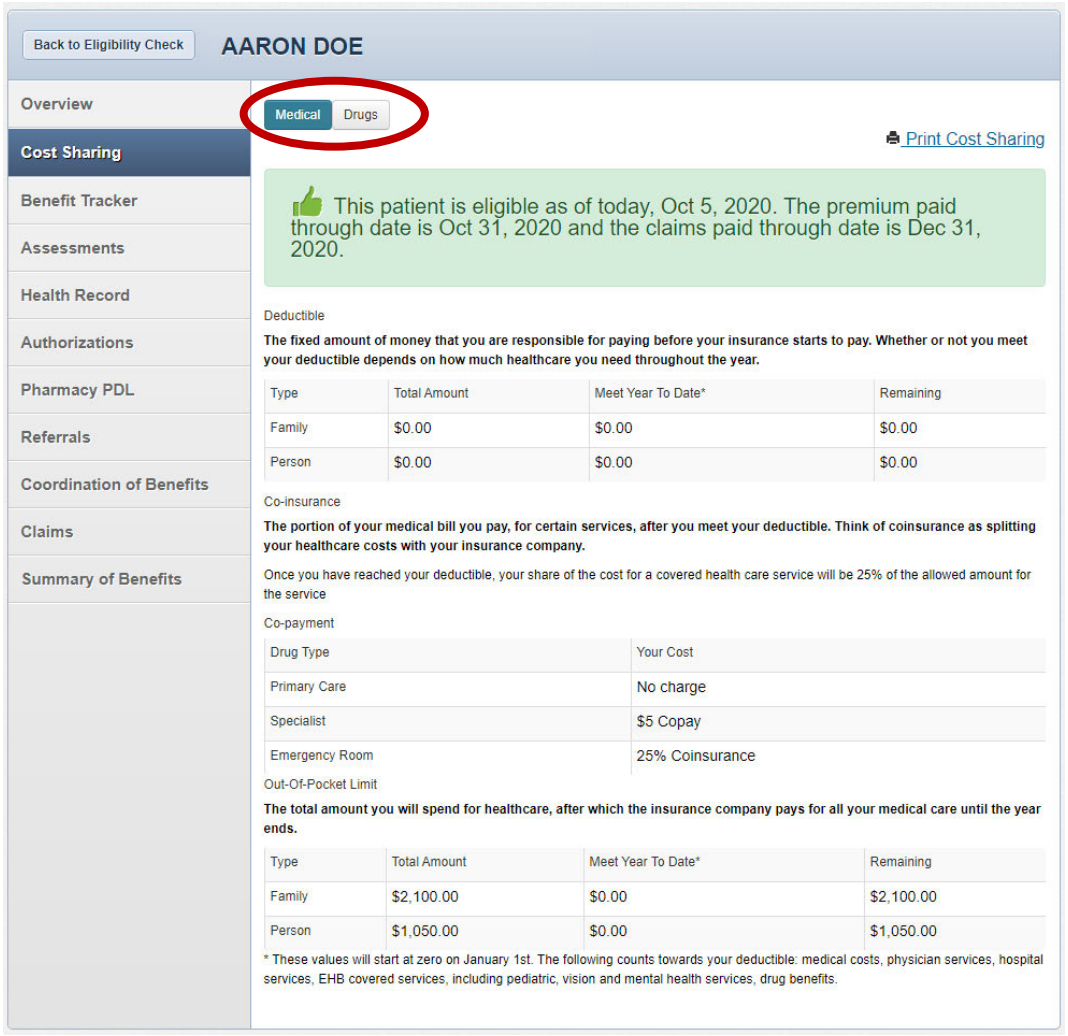
- ✓ **The Ambetter Secure Portal:** **https://www.ambetterofalabama.com/provider-resources/login.html**
  - If you are already a registered user of the **Ambetter of Alabama** secure portal, you do NOT need a separate registration!
- ✓ **24/7 Interactive Voice Response System**
  - Enter the Member ID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

Contact Provider Services: 1-800-442-1623

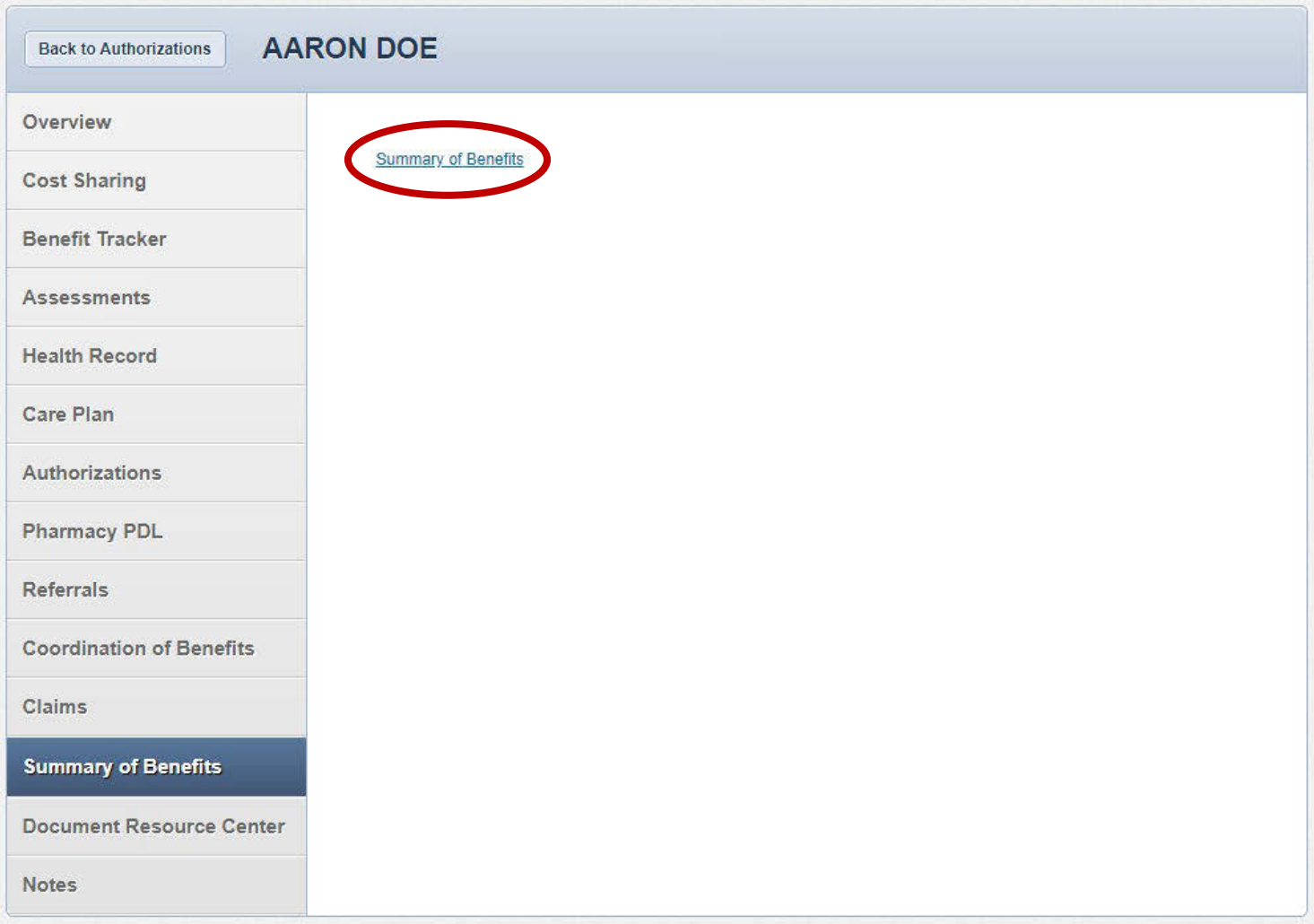
VERIFICATION OF ELIGIBILITY ON THE PORTAL



VERIFICATION OF COST SHARES ON THE PORTAL



VERIFICATION OF BENEFITS ON THE PORTAL



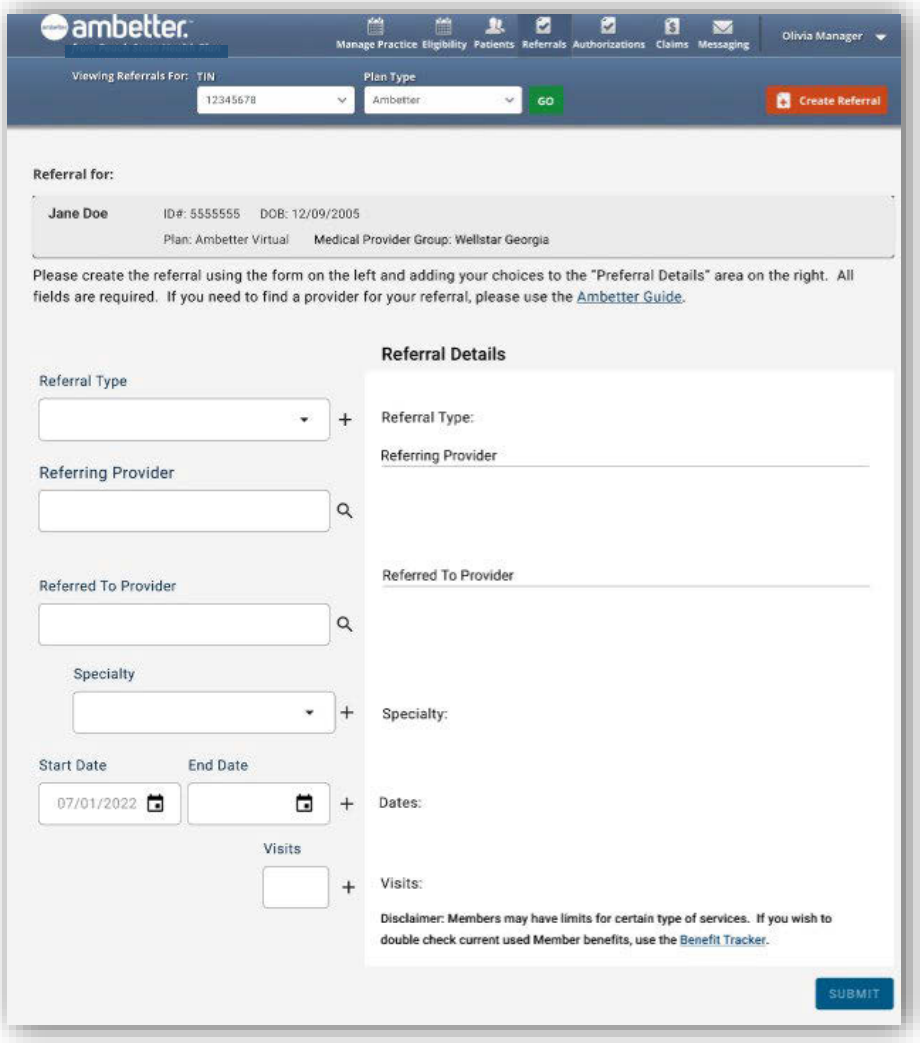
REFERRALS

AMBETTER REFERRAL REQUIREMENTS

Ambetter Plan	Referral Requirement?
Gold / Silver / Bronze	No

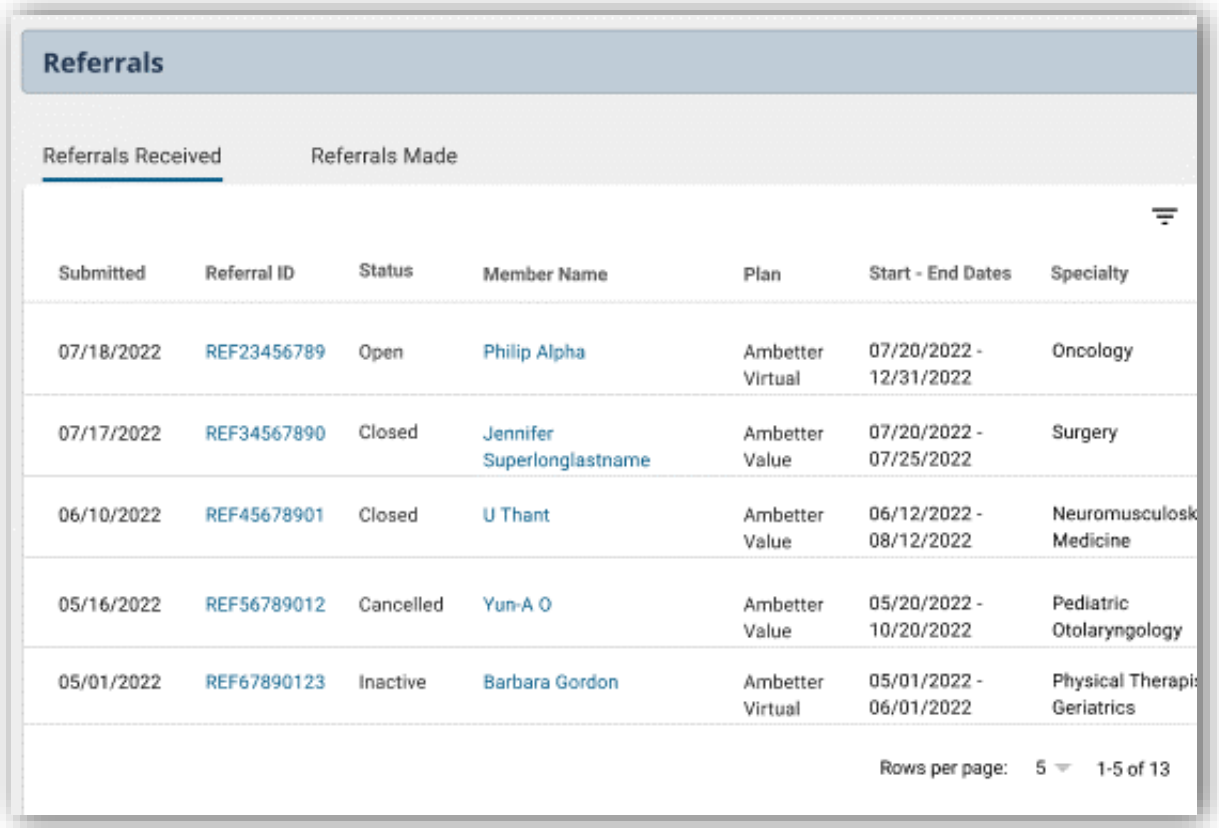
MAKING A REFERRAL: SECURE PROVIDER PORTAL

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.ambetterofalabama.com/provider-resources/login.html

This is the preferred and fastest method.

✓ Phone

1-800-442-1623

✓ Fax

Medical Inpatient: 1-833-928-0636

Medical Outpatient: 1-833-928-0638

Behavioral Health Inpatient 1-833-928-0641

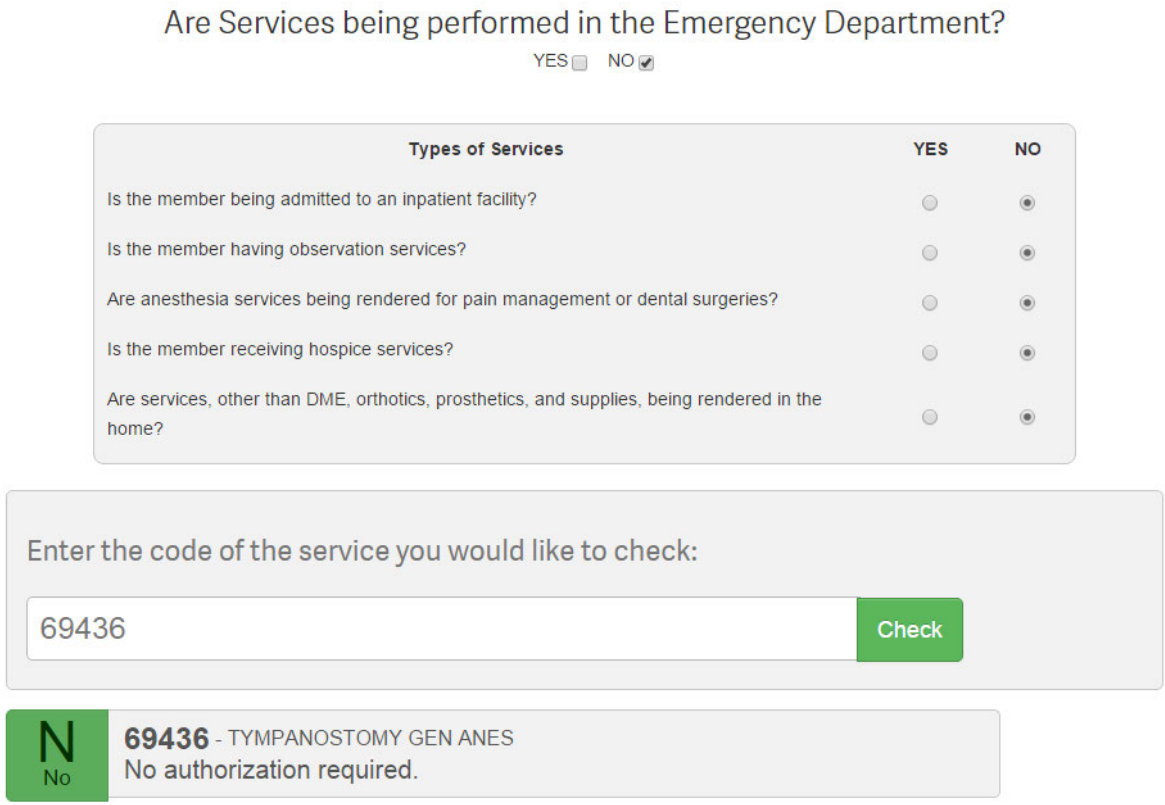
Behavioral Health Outpatient: 1-833-928-0642

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 on the provider section of the **Ambetter of Alabama** website at **https://www.ambetterofalabama.com**



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 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
Elective Admissions (*meaning scheduled inpatient in a hospital, extended care facility or rehabilitation facility, hospice facility, or residential treatment facility)*	At least 5 days prior to the elective admissions
Admission for inpatient mental health or substance use disorder	Within 24 hours of an admission
Organ transplants initial evaluation	At least 30 days prior to the initial evaluation for organ transplant services
Clinical trials services	At least 30 days prior to receiving clinical trial services
Home Health Care	At least 5 days prior to the start of care
Emergency Admission Notifications	Within 24 hours of an admission

UTILIZATION DETERMINATION TIMEFRAMES

Type of Request	Determination Timeframe	Notification timeframe
Nonurgent Pre-Service	2 Business days from receipt of all information necessary to complete the review, not to exceed 15 calendar days from the receipt of the request.	Notification not to exceed 15 calendar days from receipt of request.
Urgent Pre-Service	2 Business days from receipt of all information necessary to complete the review not to exceed 3 calendar days from receipt of the request.	Notification not to exceed 3 calendar days from receipt of request.
Urgent Concurrent	1 calendar day from the receipt of the request	Notification not to exceed 1 calendar days from receipt of request.
Retrospective	Within 30 calendar days of receipt of the request.	Not to exceed 30 calendar days from receipt of the request.

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 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.ambetterofalabama.com/provider-resources/login.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 website at **https://www.ambetterofalabama.com**

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 Mail completed Claim Dispute form to: https://www.ambetterofalabama.com

P.O Box 5010
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.ambetterofalabama.com/provider-resources/login.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 https://www.ambetterofalabama.com

SPECIALTY SERVICES & VENDORS

OUR SPECIALTY COMPANIES AND VENDORS

Service	Specialty Company/Vendor	Contact Information
High Tech Imaging Services	National Imaging Associates	1-800-278-0103 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?