We ♥ Our Medicare Members

Medicare Advantage Participating Provider Training

2021 Changes and Updates

December 2020

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Key Differences between Medicare Cost vs. Medicare Advantage

KEY DIFFERENTIATORS	MEDICARE COST	MEDICARE ADVANTAGE (MA)
NETWORK 	Signature network (MAPMG providers); access to out-of-network providers through Original Medicare*	• Medicare Advantage Signature Network (MAPMG providers + contracted providers required to meet MA network standards); no access to out-of-network providers in most circumstances • Select Network available to 5 grandfathered employer groups (Transit, City of Baltimore, Baltimore County Schools, CCBC, Harford County)
*CARD TO ACCESS SERVICES 	Medicare Red, white, and blue card	KP blue and white card
CMS PAYMENT/REIMBURSEMENT 	KP bills CMS for Medicare-covered services provided to Medicare members and is reimbursed for those services	CMS pays KP a monthly rate per member (based on county of residence and the member's health status) to manage the total care of the member, regardless of services used
BENEFITS 	Provides all benefits offered under Original Medicare, plus some extra benefits, including state-mandated benefits	• Provides all benefits offered under Original Medicare, plus some extra benefits • Does NOT include state-mandated benefits
CONTRACT NUMBER 	H2150	H2172

We have been on a multi-year journey to transition from Medicare Cost to Medicare Advantage

2017

Launched MA Conversion Program for 1/1/18 effective date

2018

Deemed and passively converted 47K DC and MD7 DPA (~30K) and Group (~17K) members for 1/1/19 effective date

2019

Engage DPA members to ***actively self enroll*** in MA:

1. ~484 Charles County DPA for 1/1/20 effective date
2. ~17,000 VA and MD3 DPA for 1/1/20 effective date (~16K in VA, ~1K in MD3)

Passively convert Group and Fed members to MA:

1. ~8,000 VA and MD3 Group and Feds for 1/1/20 effective date

2020

Engage balance* of VA and MD3 DPA members to ***actively self enroll*** in MA for 1/1/21 effective date

~10,500

COST MEMBERS AS OF 9/22:

VIRGINIA:

9,693

MARYLAND (MD3 – Calvert, Carroll, Frederick):

764

OUR SHARED GOAL:
Convert as many of our Medicare Cost members to Medicare Advantage by 12/31/20.

2021

Engage balance of VA and MD3 DPA members ***to actively self enroll*** in MA for 3/1/21 effective date

Complete MA Conversion by 2/28/21

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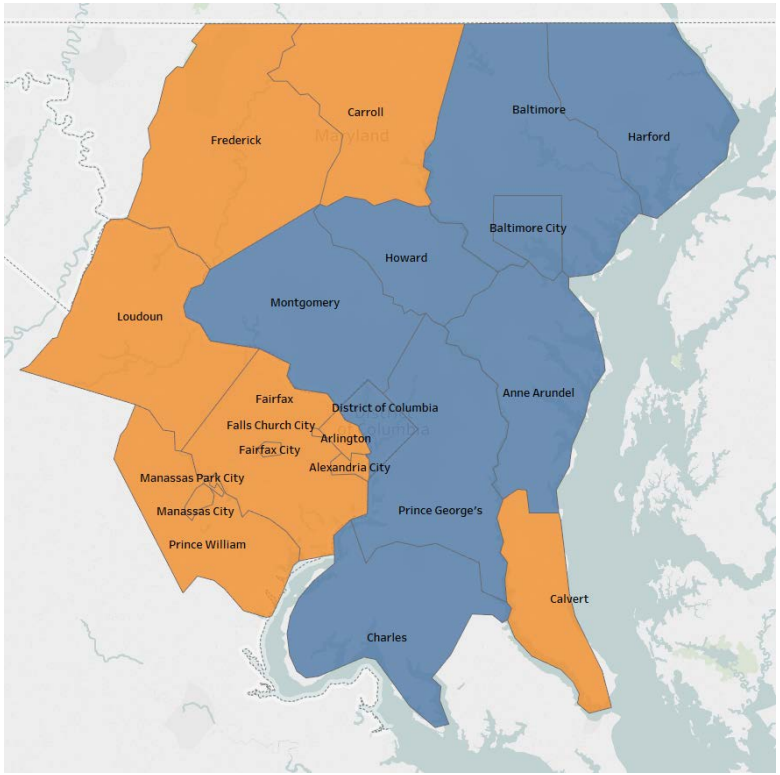
Our FINAL 2021 Medicare Advantage (MA) Conversion!!!

2020 KAISER PERMANENTE MID-ATLANTIC STATES MEDICARE SERVICE AREAS



- Every county in our Medicare service areas now have Medicare Advantage plans!
- **The counties in BLUE** have fully transitioned to Medicare Advantage. There are NO Cost members in these counties.
- **The counties in ORANGE** have **Direct Pay (DPA)** Cost members who need to **ACTIVELY ENROLL*** in Medicare Advantage (MA) by 12/31/20.
  - Virginia (VA) Counties
  - Maryland ("MD3") Counties: Calvert, Carroll, Frederick
- Group and FEHB members transitioned to the Medicare Advantage contract as of 1/1/20. There are no group members in Cost plans.

Our shared goal is to convert as many of our remaining ~11K Cost members in Virginia and Maryland to Medicare Advantage by 12/31/20!

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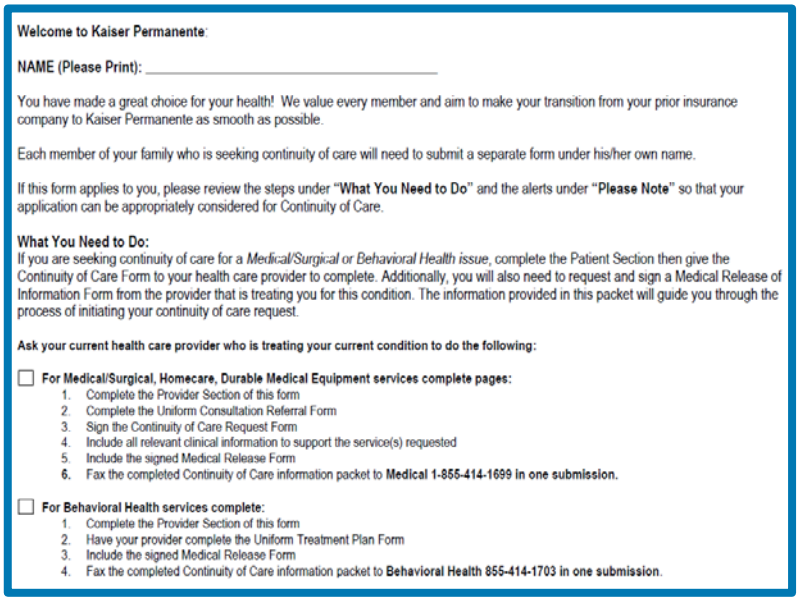
Continuity of Care may apply to some Cost members in limited circumstances

Applying for Continuity of Care:

- In limited circumstances, some Cost members may be seeing outside providers.
- Upon enrollment in MA, some members may be eligible to continue care and services and must complete a Continuity of Care form.
- **Forms (see below) can be downloaded at:** Kp.org/medicareadvantage2020



Welcome to Kaiser Permanente:

NAME (Please Print): _____

You have made a great choice for your health! We value every member and aim to make your transition from your prior insurance company to Kaiser Permanente as smooth as possible.

Each member of your family who is seeking continuity of care will need to submit a separate form under his/her own name.

If this form applies to you, please review the steps under "**What You Need to Do**" and the alerts under "**Please Note**" so that your application can be appropriately considered for Continuity of Care.

What You Need to Do:
If you are seeking continuity of care for a *Medical/Surgical or Behavioral Health issue*, complete the Patient Section then give the Continuity of Care Form to your health care provider to complete. Additionally, you will also need to request and sign a Medical Release of Information Form from the provider that is treating you for this condition. The information provided in this packet will guide you through the process of initiating your continuity of care request.

Ask your current health care provider who is treating your current condition to do the following:

☐ **For Medical/Surgical, Homecare, Durable Medical Equipment services complete pages:**
1. Complete the Provider Section of this form
2. Complete the Uniform Consultation Referral Form
3. Sign the Continuity of Care Request Form
4. Include all relevant clinical information to support the service(s) requested
5. Include the signed Medical Release Form
6. Fax the completed Continuity of Care information packet to **Medical 1-855-414-1699 in one submission.**

☐ **For Behavioral Health services complete:**
1. Complete the Provider Section of this form
2. Have your provider complete the Uniform Treatment Plan Form
3. Include the signed Medical Release Form
4. Fax the completed Continuity of Care information packet to **Behavioral Health 855-414-1703 in one submission.**

Existing Referrals:

- If a member has an existing referral to see an external provider, their care will not be impacted unless it is ***home care or DME supplies***.

HOME CARE
Number of visits provided, provider stays same

Member will receive a letter with *a new referral that adds a number of visits*. Provider will not change.

DME SUPPLIES*
Vendor change to Apria
*Not equipment

Member will receive a letter and referral letter which will *switch their supplier from non-Apria vendor to Apria*.

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Service Area Expansion in Virginia (VA): Stafford, Spotsylvania, and Fredericksburg City

- **Expanding the Medicare service area in VA will help us to better align with the Commercial services area so that we can:**
  - Serve members at all stages of life
  - Ensure members can keep their KP physicians
  - Capture age-ins and grow Medicare membership
    - 200 member growth expected in 2021
- **The Details:**
  - Starting on January 1, 2021, the Medicare Advantage service area will include Stafford and Spotsylvania counties and Fredericksburg City in Virginia.
  - We will also be adding zip codes to Charles and Frederick counties in Maryland to close some gaps in our service area. We cover these zips already in the adjoining county.
    - Charles County: 20607, 20613, 20645
    - Frederick County: 20842, 20871, 21757, 21776, 21787, 21791

Starting October 15th, members and prospective members who live in these areas may enroll in KP Medicare Advantage plans with a January 1 effective date.

2021 Benefit Changes in ALL Plans

Regional Benefit Change (all plans):

- At-home phototherapy- align Medicare with commercial Medical Coverage Policy by adding additional conditions other than psoriasis
  - (1) Cutaneous T-cell lymphoma, (2) Pityriasis lichenoides chronica, (3) Recalcitrant prurigo and pruritis, (4) Lichen planus, (5) Severe widespread eczema that has failed topical treatments, and (6) under some circumstances for Vitiligo.
  - **Members should consult their physician about this treatment**

National and CMS Changes (all plans):

- Medicare-covered Acupuncture
  - NCD issued on 1/21/20 for immediate implementation, but will have to add to plan documentation for 2021
  - Up to 20 annual visits for the treatment of chronic lower back pain (cLBP)
  - **Members should speak to their PCP to see if they qualify for this benefit**

- New additions to Preventive Care (EPS)
  - Additional lab tests (a1c, LDL, INR) and screening (retinopathy) added to our package of preventive benefits
  - Only impact for MAS is that retinopathy received after diabetes diagnosis will now be $0

- Part D Formulary changes
  - Additional brand name drugs with generic alternatives have been removed from the formulary
  - About 80 specialty drugs have been added to the formulary
  - **Impacted members will be contacted by the prescribing physician and prescribed an equivalent drug or granted an exception to continue taking their current medication**

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2021 Group Plan Changes

Change	Description
Fitness	Silver & Fit: no cost gym membership to a participating fitness facility as well as the opportunity to choose up to 3 home fitness kits. Included in all group plans!
Vision	$100 allowance at KP Vision Essentials to be used toward the purchase of glasses and contacts - This replaces the discount on glasses and contacts that was included in previous years
At-home phototherapy	In consultation with a physician, Medicare members can access at-home phototherapy for psoriasis as well as additional clinical conditions
Medicare-covered acupuncture	In January of 2020, Medicare now covers up to 20 acupuncture visits annually for the treatment of chronic lower back pain (cLBP) with a physician's referral
Expanded Preventive Care	Additional lab tests (a1c, LDL, INR) and screening (retinopathy) added to our package of preventive benefits
Part D formulary changes	Additional brand name drugs with generic alternatives have been removed from the formulary. About 80 specialty drugs have been added to the formulary.

2020 Federal Employee Health Benefits (FEHB) Plan Changes

Change	Description
Part B Premium Reimbursement	Introduction of a new High option plan (MA2) that includes a Part B Premium Reimbursement up to $150 per month and slightly higher cost sharing on medical benefits
Fitness	Silver & Fit: no cost gym membership to a participating fitness facility as well as the opportunity to choose up to 3 home fitness kits
Vision	$100 allowance to be used toward the purchase of glasses OR a $50 allowance to be used toward the purchase of contact lenses at KP Vision Essentials - This replaces the discount on glasses and contacts that was included in previous years
At-home phototherapy	In consultation with a physician, Medicare members can access at-home phototherapy for psoriasis as well as additional clinical conditions
Medicare-covered acupuncture	In January of 2020, Medicare now covers up to 20 acupuncture visits annually for the treatment of chronic lower back pain (cLBP) with a physician's referral
Expanded Preventive Care	Additional lab tests (a1c, LDL, INR) and screening (retinopathy) added to our package of preventive benefits
Part D formulary changes	Additional brand name drugs with generic alternatives have been removed from the formulary. About 80 specialty drugs have been added to the formulary.

FEHB Part B Premium Reimbursement

- How do FEHB Members Access the FEHB Premium Reimbursement?
  - ✓ In addition to the Medicare Advantage Election Form, interested members must complete the Medicare Advantage 2 enrollment application.
  - ✓ Upon acceptance of the application, members will receive a confirmation letter and a FEHB Medicare Advantage 2 Annual Documentation Submission Form.
  - ✓ In order to receive reimbursement, members must complete the FEHB Medicare Advantage 2 Annual Documentation Submission Form and provide proof of Part B premium as indicated. Members must complete this on an annual basis.
  - ✓ Members may submit their completed form and proof of your Part B premium by mail, fax, or email.
- How can members learn about their new FEHB plan option? *Stay Tuned for more information and review updated FAQ for more information.*
  - Call the FEHB Age-in Call Center: 1-877-547-4909 (TTY 711), 7 days a week, 8 a.m. to 8 p.m.
  - Visit the Fed Member Website (video forthcoming): https://healthplans.kaiserpermanente.org/federal-employees-fehb/medicare/
  - Attend Webinars – AEP Schedule TBD, Listen to recorded webinars, and attend in 2021 (twice a month in 2021)
  - Visit or listen, to be featured: WTOP Fed Site (https://wtop.com/federalnewsnetwork/) Interview, Podcast – For your benefit, Govexec.com website

Medicare Advantage Network

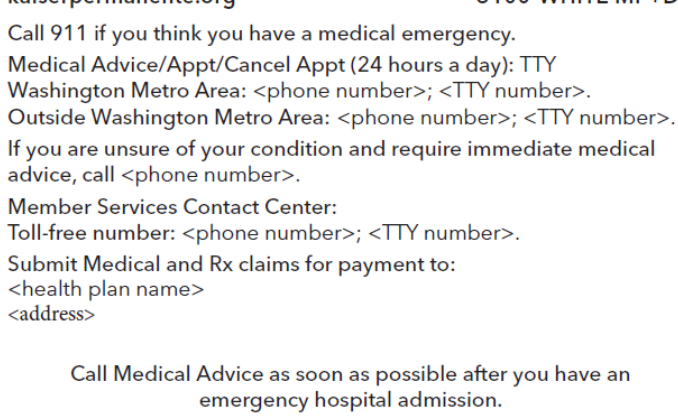
Because a Medicare Advantage member can only utilize the network of the Medicare Advantage Organization (MAO), there are rigorous network adequacy guidelines (time and distance requirements) that all MAOs must meet. These vary by the population density of a given area as well as the type of provider.

- The KP-MAS Medicare Advantage Network is its own unique network and is not the same as the Signature or Select networks used in the commercial line of business.
- The Medicare Advantage network has all MAPMG providers at the core of the network. Where there are gaps in the network, these are filled by contracts with community providers until network adequacy is met.
- All providers in the Medicare Advantage network required to meet network adequacy are listed in the provider directory.
- Members may choose from any provider in the network, though referrals and prior authorization may apply.
- Under both products, members in hospice may go to any hospice provider and have their services paid for by Original Medicare.

ID Cards

Members may have different ID cards depending on whether they are in a plan with the Medicare Advantage Signature network or the Medicare Advantage Select network and whether their plan includes Part D prescription drug benefit. The differences appear in the card color as well as the information included on the card.

	MA Signature	MA Select	Plans with No Part D
Card Color	White	Tan	White
Provider Information included	No	Yes	No
Rx Info Included	Yes	Yes	No



Medicare Advantage ID Card

The Medicare Advantage ID Card will look very similar to Cost but have a different contract number and product name.

Front

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Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

MEDICAL RECORD NUMBER <XXXXXXXX>

<plan name><plan type>

<Member Name>

RxBIN: <011859> RxGRP: <MA>

RxPCN:<MACMSA> ISSUER: <80840>

MedicareRx Prescription Drug Coverage

CMS-<contract number> <PBP>

This card is for identification only. Possession of this card confers no right to services or benefits unless the holder is a member complying with all provisions of an applicable agreement.

Back

kaiserpermanente.org 3100-WHITE MP+D

Call 911 if you think you have a medical emergency.

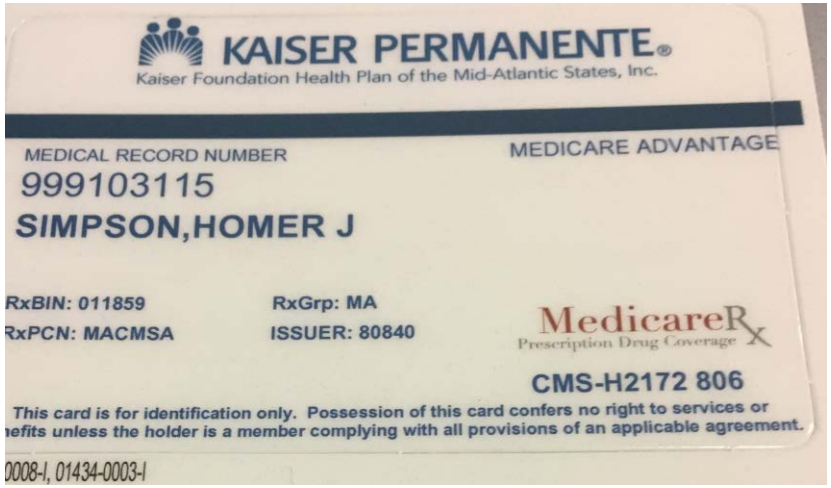
Medical Advice/Appt/Cancel Appt (24 hours a day): TTY
Washington Metro Area: <phone number>; <TTY number>.
Outside Washington Metro Area: <phone number>; <TTY number>.

If you are unsure of your condition and require immediate medical advice, call <phone number>.

Member Services Contact Center:
Toll-free number: <phone number>; <TTY number>.

Submit Medical and Rx claims for payment to: <address>
<health plan name>.

Call Medical Advice as soon as possible after you have an emergency hospital admission.



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Outpatient Dialysis Coinsurance

Effective January 1, 2020, there was a 20% coinsurance added to all outpatient dialysis services, including peritoneal dialysis, hemodialysis, and home dialysis.

What does this mean for our members?:

Medicare members who utilize outpatient dialysis services experienced an increase in cost as they moved from paying $0 cost sharing to a 20% coinsurance. Certain items, such as kidney disease education, will remain at $0. The costs incurred will go toward the member's Maximum Out of Pocket (MOOP).

Which plans were impacted?:

All Medicare Advantage and Medicare Cost plans for individuals. This does NOT impact Medicare group or Medicare FEHB plan members.

Is there financial assistance available to members?:

Patient Financial Assistance can assist members with the cost of services received in Kaiser Permanente facilities. Nephrology social workers will also be working with members to find additional resources. No member will be denied dialysis services due to an inability to pay. No member will lose their Kaiser Permanente Medicare Advantage coverage due to an inability to pay.

Why did we make this change?

To align with the market and Medicare standard for cost sharing in this benefit category

Compression Garments

Medicare covers compression garments for patients only under a very limited set of circumstances. This benefit expands the circumstances under which a member can get custom-made compression garments covered by the health plan.

What do our members get?:

Compression garments in alignment with the commercial MAS medical coverage policy, which covers compression bandages and garments in the following circumstances. Member cost sharing remains the same, which is 20% coinsurance.

A. Treatment of lymphedema, including:
- **1.** Primary edema from congenital defect (hereditary edema);
- **2.** Secondary edema, acquired and due to lymphatic obstruction or interruption;
- **3.** Cancer or cancer related treatment for breast cancer, surgery or radiation therapy;
- **4.** Post-mastectomy lymphedema syndrome and other lymphedema

B. Treatment of an open venous stasis ulcer;
C. Treatment of chronic venous insufficiency with venous stasis ulcers;
D. Hypertrophic scarring and joint contractures following burn injury or scarring from surgery; or
E. Post amputation compression therapy, e.g. stump wraps, shrinkers, and shapers.

Which plans include this benefit?:

All Medicare plans, including Medicare Cost plans, Medicare Advantage Value plans, Medicare group plans and Medicare FEHB plans.

How do members access this benefit?:

If the member is in need of a compression garment and has one of the clinical indications above, the item will be approved and the member will be responsible for their contribution.

Why do we want our members to have this benefit?:

To support care delivery partners as they design treatment plans for our members that will maintain and improve quality of life.

Enrollment and Eligibility

Participating Providers enrolled with KP HealthConnect AffiliateLink may verify eligibility and benefit information online by logging on at: www.providers.kp.org/mas

Participating Providers or members may call Member Services at 1-855-249-5019 or for TTY 1-866-513-0008 regarding:

- General enrollment questions
- Clarification of eligibility verifications
- Clarification of member benefits
- Members terminated greater than 90 days
- Members presenting with no Kaiser Permanente identification number
- Clarification of claims issues

Appointment and Access Standards

Per the Medicare Managed Care Manual, Chapter 4 - Benefits and Beneficiary Protections, Section **110.1.1 – Provider Network Standards**

- Hours of operation are convenient to, and do not discriminate against, enrollees.
- When medically necessary, services are available 24 hours a day, 7 days a week
- Examples of reasonable standards for primary care services are:
  - (1) urgently needed services or emergency - immediately;
  - (2) services that are not emergency or urgently needed, but in need of medical attention - within one week; and
  - (3) routine and preventive care - within 30 days

Referrals and Authorizations

Specialty Care Referrals

- Initial Consultation
  - Referral must be authorized by PCP or Specialist
  - Referral valid for 90 days (3 months), or as otherwise specified on the referral

- Additional Visits and Expired Referrals
  - After an approved initial consult you do not have to call the PCP to request additional visits
  - Complete a Maryland Uniform Consultation Referral Form to initiate a new request, fax to UMOC for processing
  - UMOC FAX Numbers: 1-800-660-2019 – Alternate Fax: 855-414-1693

Referrals and Authorizations

Utilization Management Operations Center (UMOC)	
Referral Management Unit: 8:00am – 4:30pm, weekdays	Concurrent Review Unit: 8:30am – 5:00pm, weekdays
Home Care/DME Unit: 8:30am – 5:00pm, weekdays	Emergency Care Center (ECC): 24/7, 365 days/year

Referrals, authorizations hospital observation & inpatient admissions
General Number (listen for prompts): 1-800-810-4766
Fax Numbers • Specialty Care Referrals: 1-800-660-2019 or 855-414-1693 • Homecare/DME (Please send clinical information): 855-414-1695 • Rehab Re-Authorizations (Please send clinical information): 855-414-1698 • DCSM Concurrent Review: 855-414-1704 • NOVA Concurrent Review: 855-414-2659 • Baltimore Concurrent Review: 855-414-1702 • Emergency Care Center: 855-414-2634

Claims & Billing Procedures

Kaiser Permanente is the primary payor for Medicare Advantage. Claims should be sent to Kaiser Permanente, not CMS. However, the same billing requirements for CMS are applicable to all claims billed to Kaiser Permanente. Please verify the member's plan to ensure that the claim is submitted to the correct payor.

Billing Address:
Mid-Atlantic Claims Administration
Kaiser Permanente
P.O. Box 371860
Denver, CO 80237-9998

Clearinghouse Payor IDs for KP:
ChangeHealthcare: 52095
Office Ally: 52095
Availity: 54294
OptimumInsight/Ingenix: NG008
Relay Health: RH010

Timely Filing: 180 days (6 months) from date of service

Timely appeals filing: 180 days (6 months) from date of denial

"Clean Claim": Standard format/completed fields, attachments, current industry standard data coding

All patient services must be billed on CMS 1500 or UB04

Provider Appeals

All provider appeals should be sent to:

Mid-Atlantic Claims Administration
Kaiser Permanente
P.O. Box 371860
Denver, CO 80237-9998

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