2021 Q3 All Provider Forum

Zoom
September 29, 2021

BlueCross BlueShield Arizona

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Agenda

1. Welcome, Introductions, Provider Survey — 5 minutes
   - Charlotte Whitmore, VP Network Operations
   - Kijuana Wright, Dir. Network Operations
   - Aimee Perez, Dir. Contracting
2. Medicare CAHPS Survey & The Provider Impact — 10 minutes
   - Georgann Moore, Member Experience Advisor
3. Bright from the Start Program — 10 minutes
   - Kelly Lalan, LMSW, Clinical Care Coordinator
4. Children's Behavioral Health Services Fund — 10 minutes
   - Sarah Hester, Youth and Young Adults Project Coordinator
5. Diversity, Equity and Inclusion — 10 minutes
   - Jermaine Barkley, Diversity, Equity and Inclusion Leadership Council, Chairman
6. Provider Resources — 10 minutes
   - Jadelyn Fields, Network Provider Service Manager and Educator
7. Q & A — 10 minutes

Provider Satisfaction Survey

COMING JANUARY 2022

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Medicare CAHPS Survey & The Provider Impact

Georgann Moore

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CAHPS Survey Objective

The Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS®) study is given to Health Choice Pathway members.

- Captures consumer-reported experiences with health care.
- The Centers for Medicare and Medicaid Services (CMS) uses this information to assign Star Ratings to health plans.

CAHPS Survey Changes

- Formula changes for contract year 2021, which impact 2023 Star Rating scores.
- CAHPS scores previously 2x weighted, will now be **4x** weighted.
- CAHPS surveys ask beneficiaries (or caregivers) about their experience with, and ratings of, their providers as well as health plans. Includes the perception of whether those interactions are positive or negative such as:
  - How easy it is to access care
  - Communication from providers
  - How well consumers understand medication information

CAHPS Survey - the Member Experience

- The member/patient experience is not equal to their satisfaction.
- The key difference is that CAHPS surveys capture the member/patients' **opinion of the experience** was, not if they were satisfied.
- Experience and satisfaction are adjacent, but they aren't the same thing.
  - It is possible for a member/patient to perceive their experience as acceptable but not be satisfied with the results.

Ideally, we want to provide positive experiences *and* keep members/patients satisfied.

Getting Needed Care

- Patients rate how often it was easy to get appointments with specialists and to get the care, tests or treatment they needed in the prior six months.

Recommendations:

- Make scheduling as easy as possible.
- Ask staff to schedule specialist appointments and write down the details for your patients.

Getting Needed Care, Cont.

Getting Needed Care Improvement Strategies

- Assess CAHPS data by health system, PO, and/or network. Communicate results and identify outliers. Evaluate with HEDIS data, complaints, appeals and/or quality of care concerns, and communicate. Identify issues, prioritize and implement improvement activities.
- Work with providers to support patients in navigating health care and remove obstacles. Support and encourage providers to take innovative action to improve access. Examples include: Serve patients quickly, treat urgent issues promptly, minimize wait times, follow-up about appointment times and test results. Another is to develop an in-depth referral/decision-making guide for PCP's to prepare for/with patients explaining need, urgency, patient expectations and responsibilities, and preparations for seeing a specialist.
- Support members and collaborate with providers to enhance access to care through innovative, proactive approaches within/across Care Management, Chronic Care, and Quality Management - including home care opportunities. Work with providers to identify and resolve opportunities.
- Continually assess, revisit and simplify plan requirements/processes (i.e., UM) impacting access to care, tests, or treatment. Seek opportunities to improve processes and procedures.
- Review and simplify precertification/auth/referral policies/procedures for both member and provider, including messages and communications. Cross-reference with complaints, concerns, and quality of care issues. Improve and clarify processes and communications.
- Evaluate and simplify member communications, assuring that members are clearly told why something is not approved. When appropriate, offer suggestions for next steps or alternatives.
- Ensure Customer Service representatives are able to accurately advise members of available alternatives for care, such as walk-in clinics, urgent care, specialists, labs, etc.
- Establish a specialist referral hotline for providers and members.
- Explore alternative telecommunication technologies to expand access to care: telephone, telehealth, telemedicine, patient portals, etc.

Voice of the Member

I would like the **flexibility to be on call to fill an appointment that was cancelled**. The process for this right now is you **have to call each day** to see if there has been a cancellation. They won't put you on a list.

During my annual physical, my GP noticed an aberration in my EKG. He recommended that I visit a cardiologist. As a result of that visit, he recommended I go to a surgeon**. I saw the surgeon on a Friday** and had **quadruple bypass surgery on Monday**.

In an experience with an in-home provider, I was **surprised how much they covered**. She **made me comfortable.**

I **don't feel that my twice-yearly visits** on Medicare are really **sufficient**. I have a lot of health issues and sometimes **I wish I could get some extra tests**, just to set my mind at ease.

Before we retired, **we had decent coverage at a reasonable price**. Thank goodness that was when I needed it the most. **Now it is pretty expensive** and **medical care is a big worry**.

Getting Appointments & Care Quickly

- Patients rate how often they were able to schedule an appointment and get care as soon as needed.
- Patients also rate how often they saw the person they came to see within 15 minutes of their appointment time.

Recommendations:

- Contact your patients when delays are expected using telephone, text or email.
- Break up wait times by moving patients from the waiting room into an exam room to take vitals.
- Advise patients of the best days or times to schedule appointments.

Getting Appointments & Care Quickly, Cont.

Getting Care Quickly Improvement Strategies	Voice of the Member
• Assess CAHPS data by health system, PO, and/or network. Communicate results and identify outliers. Correlate with HEDIS data, complaints, appeals and/or quality of care concerns, and communicate. Support and encourage providers to take innovative action to improve access. • Support members and collaborate with providers to enhance routine and urgent access to care through innovative, proactive approaches within Care Management, Chronic Care, and Quality Management. Work with providers to identify and resolve opportunities. • Discuss and engage providers/staff on scheduling best practices, how to improve access to routine/urgent care. Consider on-line scheduling or scheduling routine appointments well in advance, e.g., 12 months. Provide tools, resources, support and assessment. • Inform patients of expected wait times during check-in. Keep them informed if there is a delay. Communicate delays apologetically and offer to reschedule if necessary. • Support, encourage and assist in approaches toward open access scheduling. Allow a portion of each day open for urgent care and/or follow-up care. • Contract with additional providers for urgent and after-hour appointments/availability. • Explore partnering with 24 hour urgent care or walk-in clinics. • Educate providers and staff about Plan and regulatory appointment wait time requirements or standards (i.e., CAHPS, CMS, States, etc.) . Identify opportunities for improvement. • Provide members streamlined tools and resources (links, apps, etc.) about benefits, providers, referrals, scheduling appointments, and costs. Identify options and hours available, and include alternatives, including practices with evening and weekend hours. Consider alternative convenient sources of information, e.g., newsletter inserts, refrigerator magnets.	My doctor has a new feature where you can **schedule your own appointment via his web portal**. It is quite **easy and convenient**. For **urgent care**, I was able to be **seen that day**, as they leave a gap in the days schedule for that. When my PCP was only working part time, due to her own health issues, **it was difficult to get in** to see her. I was always **referred to another physician** on staff and I tried to be **understanding of the situation** and accept that I needed to be flexible. If I feel it is **critical to get in**, I may explain to the receptionist my concerns. Usually, they are **willing to work around or into schedules**. An ideal process would be **setting up appointments online**, for both in-office and telemedicine appointments.

Doctors Who Communicate Well

Question asked how often their personal doctor:

- explained things clearly,
- listened carefully,
- showed respect, and
- spent enough time with them.

Recommendations:

- Develop tools and guidance for patients to use during appointment times to assist with guiding the conversation regarding specific topics.
- Create patient focus groups to gain feedback from members on their communication preferences.
- Use a variety of communication methods (written, illustrations, etc.).

Doctors Who Communicate Well, Cont.

How Well Doctors Communicate Improvement Strategies

- Cultivate a patient-centered care philosophy and programs across the provider network.
- Support, communicate and educate providers about the vital medical importance of effective doctor-patient communication (i.e., reduced hospitalizations & ER visits , improved adherence).
- Provide readily available recommendations, tools and guidance to all providers to support and enhance communication skills and effective conversation skills with patients. Providers need to: Provide thorough explanations, use written materials, illustrations and/or examples to help patient's understand, repeat the patient's concern and then address the topic, ask clarifying questions, repeat key information and confirm patient understanding of concepts, maintain eye contact, avoid medical jargon and technical language - use simple terms, tailor language to the patient's level of understanding, avoid rushing the patient and distractions, use constructive verbal responses and non-verbal cues, apply empathy and interest in response to concerns, be kind, avoid condescending language or actions, address questions and concerns-as much time as necessary, schedule adequate time for each visit, and follow-up after tests or procedures. Help patients feel at ease during invasive exams, tests, and procedures, and prepared for discomfort. Prioritize an empathetic, personable, considerate bedside manner.
- Collaborate and share with providers tools, resources, and best practices to support, or reinforce, a complete and effective information exchange with all patients (e.g., a summary of medical record or health assessment to facilitate an effective health or wellness discussion, patient testimonials - perhaps from focus groups - of effective and ineffective communication techniques, provide tips and/or testimonials in provider newsletters).
- Develop tools and guidance for patients to optimize appointment time with specific topic-based conversation guides and question checklists to use during appointments with providers (e.g., healthy conduct & lifestyle choices, Doc Talk).

Voice of the Member

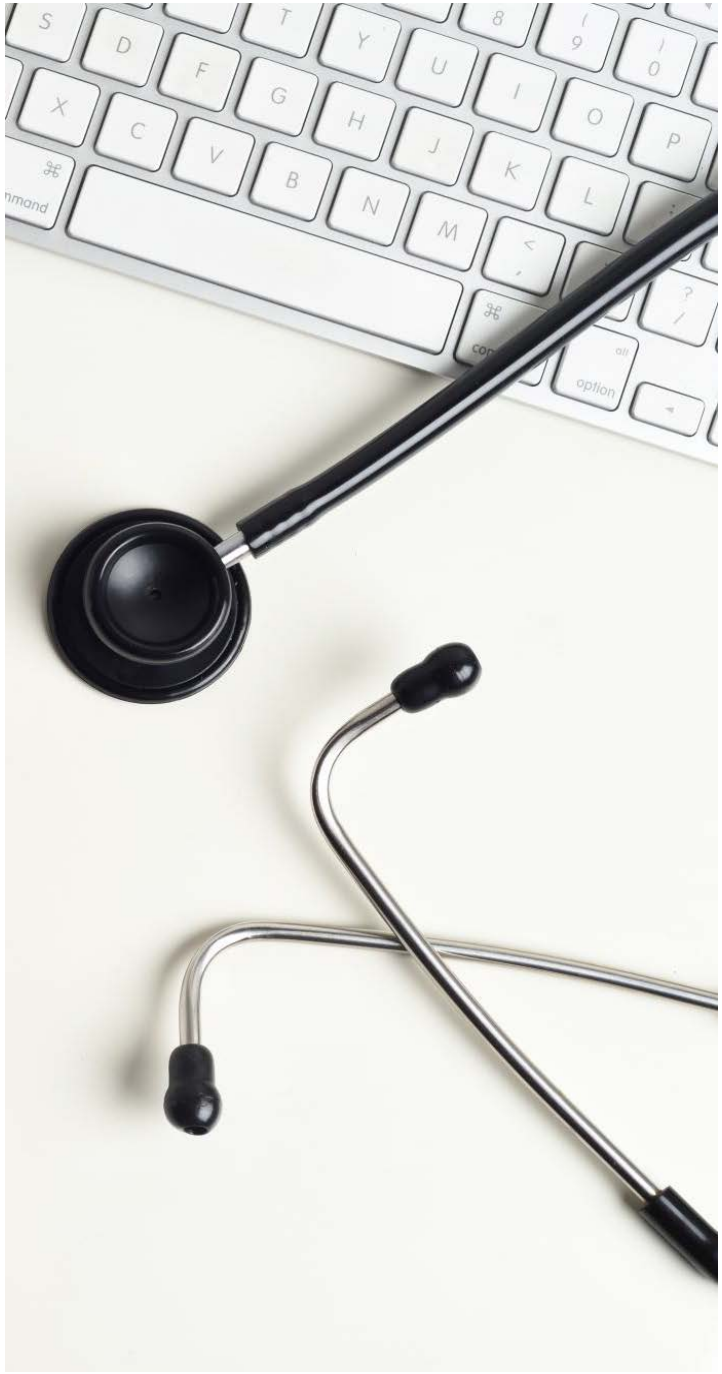
If I tell a doctor **I have a concern** and he then **looks into the issue**, either by a physical exam or looks up the issue and **gets back to me**, I feel he has taken my concerns seriously. On the flip side, when a doctor is **dismissive of my problem**, I feel **very disrespected**.

I can remember being with a **doctor whose manner was brusque**, and who seemed to be in a **hurry to end the discussion**. I felt **disrespected**, and I was **left with a lack of confidence** in that doctor.

I always **make sure I question the doctor** and tell him **I am not understanding**. I ask for his **explanation again until I do understand**.

My best experience with this was when one of my **doctors drew a picture of what was happening** in my body. It made it **much easier to understand** and **ask questions**.

They **rush you in and out** so fast that you feel guilty trying to keep them there long enough to ask them more questions. Sometimes 10-15 minutes or shorter is not enough time when you are there for the first time.



Coordination of Care

Rating of physician's familiarity with:

- member's medical history and prescriptions,
- how well physicians are following up with patients after tests and
- how well personal doctors are managing care with specialists or other providers.

Recommendations:

- Encourage patients to bring a list of medications to each appointment to review and discuss concerns.
- Coordinate with other providers involved in the individual's care to ensure a wholistic approach in their care plan.

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Coordination of Care, Cont.

Coordination of Care Improvement Strategies

- Inform, support, remind and facilitate providers about coordination of care expectations, timely notification requirements, and standards of care for post-visit follow up to all PCPs. All provider communications should focus on these vital communication between PCP's and Specialists. Explore options to support and facilitate these vital communications.
- Assess the status and consistency of coordination of patient care, communication, and information shared within and across provider networks. Assure prompt feedback, standards.
- Support and facilitate a patient-centered care management approach within and across provider networks. Facilitate a complementary plan-based patient centered care management approach. Expand/encourage practice-wide patient-centered care programs. Support these programs with tools, resources, tips and advice for setting goals, establishing standards, and tracking progress.
- Discuss the pros and cons of each medication before prescribing, including side effects and interactions. Listen to patient medication feedback. Partner with patients on a medication treatment plan. Recognize that cost may be an issue, and give providers and members alternatives, resources and methods to address. Encourage patients to bring a list of all medications, including dosage and frequency to all appointments. Encourage providers to prompt patients to do the same for their appointments.
- Explore potential of aligning information flow/EHRs to better integrate, support or facilitate patient care, care coordination and vital medical and personal information among providers. Examples include: By patient, grant access to complete medical records to their other providers. Ensure that other doctors/PCPs have access to up-to-date patient information. Allow patients to access their own records. Contact known providers to get missing information.
- Encourage providers to prompt patients AND patients to prompt providers, i.e., mutual interactions that review and discuss care, tests and/or treatments involving other providers. Ask and share specific details about any recent specialty care since their last visit.

Voice of the Member

Currently, each provider has a **unique records system** and they **do not talk to each other**. Some of them send copies to my PCP but most do not.

My doctor **has all of my medical records** on the computer that **he has access to during the visit**. At times, he will refer to them during my visit.

I **had to tell the doctor everything** that **would have been in the file**, either in the doctor notes, nurse notes, test results or scheduled surgery, and this has happened more than once. There seemed to be **no coordination going on at all**.

If they **do not have all of the information** that they need, they **ask me for details** and also the doctors I have had before. The doctor's office will **give the other doctors a call** and **find out the information** that they need.

My doctors do **have access to my previous records**. Unfortunately, they **all do not read up on it before your appointment**. You spend 30 minutes answering questions in the office and most of the time no one reads it.

How Does This Correlate to Overall Health Care Quality Rating?

With Health Care Rating		
Q17	Personal doctor overall	0.5974
Q10	Got care/tests/treatment	0.5604
Q47	Drug plan overall	0.5469
Q18	Dr. had medical records/info	0.4777
Q31	Specialist overall	0.4653
Q4	Got urgent care	0.4517
Q14	Dr. listened carefully	0.4422
Q16	Dr. spent enough time	0.4374
Q38	Health plan overall	0.4318
Q8	Seen within 15 minutes of appt.	0.4213

Key questions that are highly correlated to Health Care Quality

Bright from the Start

Kelly Lalan LMSW, Clinical Coordinator

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Bright from the Start

Bright from the Start is a parent-to-parent connection program that provides support, education, and assistance with navigating both the behavioral health and physical health systems.

The program's aim is to ensure a bright start for families by connecting pregnant and post-partum parents' with other parents who may assist with doctor appointments, nursing services, behavioral health services, community resources, education/parenting through developmental stages, etc.

Foundational Performance Measures

- Improve timeliness of prenatal care (MPS 80%) and postpartum care (MPS 64.0%)
- Increase rate of behavioral health engagement (Goal: 65%)
- Add the updated PMs

Bright from the Start

Who is eligible for referral:

- Network purchase program
- Members with an SMI designation who are pregnant
- Members who are up to 90 days postpartum.

*If you have a pregnant or parenting member that does not have an SMI designation or has children, services and supports are still available. Please contact the HCA Early and Periodic Screening, Diagnostic and Treatment (EPSDT) department for additional information at: HCHEPSDTCHEC@healthchoiceaz.com

Bright from the Start

When will referrals be accepted?

Bright from the State will be kicking off in Quarter 4 of 2021. Look for more information gin the coming months about the referral process.

How providers access the program on behalf of the member:

This program's initial pilot area includes Yavapai, Coconino, and Mohave County

Family Involvement Center (FIC): Yavapai & Coconino County

Mentally Ill Kid in Distress (MIKID): Mohave County

If you or your agency needs additional support and or information related to this program, please contact Health Choice Arizona's Care Management Department: HCH.HCICICM@healthchoiceaz.com.

Children's Behavioral Health Services Fund

Sarah Hester, Youth and Young Adults Projects Coordinator

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Children's Behavioral Health Services Fund

What is it?

"Jakes Law" Senate Bill 1523 or Children's Behavioral Health Services Fund (CBHSF). Spring 2020, the Arizona Legislature passed Jake's Law, funding behavioral health services for uninsured and underinsured children who were referred through an educational institution for services provided through June of 2022. Funds were provided to the state RBHA's to be administered.

Here is the link to the AHCCCS site and the Senate Bill that provides more information.

https://www.azahcccs.gov/AHCCCS/Initiatives/BehavioralHealthServices/#CurrentProjects

https://legiscan.com/AZ/text/SB1523/id/2161283/Arizona-2020-SB1523-Chaptered.html

Children's Behavioral Health Services Fund

Why did the Legislature provide this opportunity for children?

Funding to provide the full array of AHCCCS Children's System of Care Services for children who have no insurance, or the insurance they do have does not cover the full array of Medicaid covered services.

Referred children who do not qualify for Medicaid or MHBG-SED services would now be able receive services from your Health Home.

Children's Behavioral Health Services Fund

What is the school's responsibility?

- Schools who meet the requirements of the law:
    1. Posting CBHSF policy on their website and
    2. Obtaining parental consent, are able to refer students for behavioral health services, regardless of a student's Medicaid eligibility.
- AZ Department of Education is outreaching all schools to provide guidance on the schools and their responsibility for doing this.
- AHCCCS has stated that behavioral health providers may act in good faith that the school is following the law when a referral is made and take the referral.

Children's Behavioral Health Services Fund

How are referrals to occur?

- Behavioral Health Homes in contract with HCA in the north, have historically worked with schools and school districts in their areas, receiving referrals. The current processes you have in place would be continued.

- AHCCCS has posted to their website and is distributing a document that lists all Northern AZ Health Homes that serve children as referral sources for behavioral health services.

Children's Behavioral Health Services Fund

What behavioral health services are covered?

- All Medicaid covered services are available through these funds. See AMPM 310-B

- Please Note: CBHSF funding does not constitute an entitlement for any individual to receive services

- https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/310B.pdf

Children's Behavioral Health Services Fund

Are deductibles/copayments covered with CBHSF fund?

Deductibles/copayments are able to be covered with these funds per AHCCCS

What age of children are served with these funds?

2.75 to 21.9 years old -Per ARS Title 15-821

Should CBHSF be used for any school referral?

- No, you would determine eligibility for a child as with any referral.
- The school does not know what funding source a child would be eligible for.
- A referred child/family may be eligible for Medicaid, or MHBG-SED, and so these funds would be payor of last resort

Children's Behavioral Health Services Fund

What is the payment responsibility hierarchy?

- Legislature has deemed these funds to be payor of last resort to include any commercial insurance the family may have.
- Payment responsibility should come first, Non-Medicaid Third Party Coverage> then MHBG-SED funding> finally, CBHSF
- CBHSF funds should be used if there is no third party coverage, if there is no more MGBG-SED funding or if the child is not eligible for SED

Do these services have to be provided in a school setting?

No, these services can be provided where it meets the family's needs, the same as any other Medicaid eligible child.

Children's Behavioral Health Services Fund

How do I enroll a child under CBHSF who does not meet any other payment criteria?

This would be a State Only Enrollment AND Referral Source as ADE in the DUGLESS Portal

How do I bill for CBHSF clients?

All claims for CBHSF are to be submitted with a V1 modifier

Children's Behavioral Health Services Fund

Who do I go to if I have questions?

Victoria.Tewa@healthchoiceaz.com

Sarah.Hester@healthchoiceaz.com

Your Provider Performance Representative

Diversity, Equity, and Inclusion Leadership Council

Diversity, Equity, and Inclusion Leadership Council (DEI LC)

September 29th, 2021

DEI LC Overview

Objective: To inform Q3 2021 Provider Forum on DEI Initiatives within BCBSAZ/HCA

DEILC Members and Introductions

Jermaine Barkley (Chair)
First Episode Psychosis Grant Coordinator
Health Choice Arizona

Eddie Espinoza (Secretary)
Enterprise Production Support Analyst
IT Services Mgmt

Kijuana Wright
Director of Network Operations
Health Choice

Gerald Bohulano
Corporate Communications Mgr.
PR & Internal Communications

Nelly Diaz
HR Business Partner
Human Resources

Shabnan Elston
Health Promotions Executive
Health Promotion and Wellness

Gerilene Haskon
Tribal Relations Coordinator
Health Advancement

Becca Langum
Dir. Blue Card Operations
Commercial Operations

Kathryn Mattson
Dir. Small Group Sales
Individual/Small Group Sales & Support

Emeka Oranyeli
Corporate Medical Director, Individual Clinical Ops.
Clinical Operations

Kevin Scott
Mgr. Customer Service Ops
BlueCard Host Unit

Krystal Soza
Payment Ops Lead Analyst
FSS Velocity & Payments

Archana Subhash
Digital Product Lead
Marketing Customer Experience

Starlett Thomas
CAPS, Customer Care Solutions
Customer Care Solutions

Melissa De La Rosa
Executive Admin Asst.
Legal

Agenda

- Strategic Goals and Objectives
- Council Structure
- ELT Pledge
- Accomplishments
- Q&A

Strategic Goals

1. Create an inclusive environment where every employee feels valued
2. Establish a baseline understanding of diversity, equity, and inclusion throughout the BCBS workforce
3. Foster a diverse internal and external talent pipeline
4. Support BCBSAZ efforts in addressing health disparities

Strategic Goal 1

Goal 1: Create an inclusive environment where every employee feels valued.

Objective 1	Objective 2	Objective 3
Establish a communications strategy for collecting data, passing, and receiving information	Develop and launch Affinity Groups	Support development of equitable performance and reward standards.

Strategic Goal 2

Goal 2: Establish a baseline understanding among BCBSAZ employees of topics as they relate to diversity, equity, and inclusion.

Objective 1	Objective 2	Objective 3
Develop a Diversity Education Program	Ensure some elements of DEI is included in all BCBSAZ Leadership Programs	Develop an annual DEI event

Strategic Goal 3

Goal 3: Foster a diverse internal and external talent pipeline.

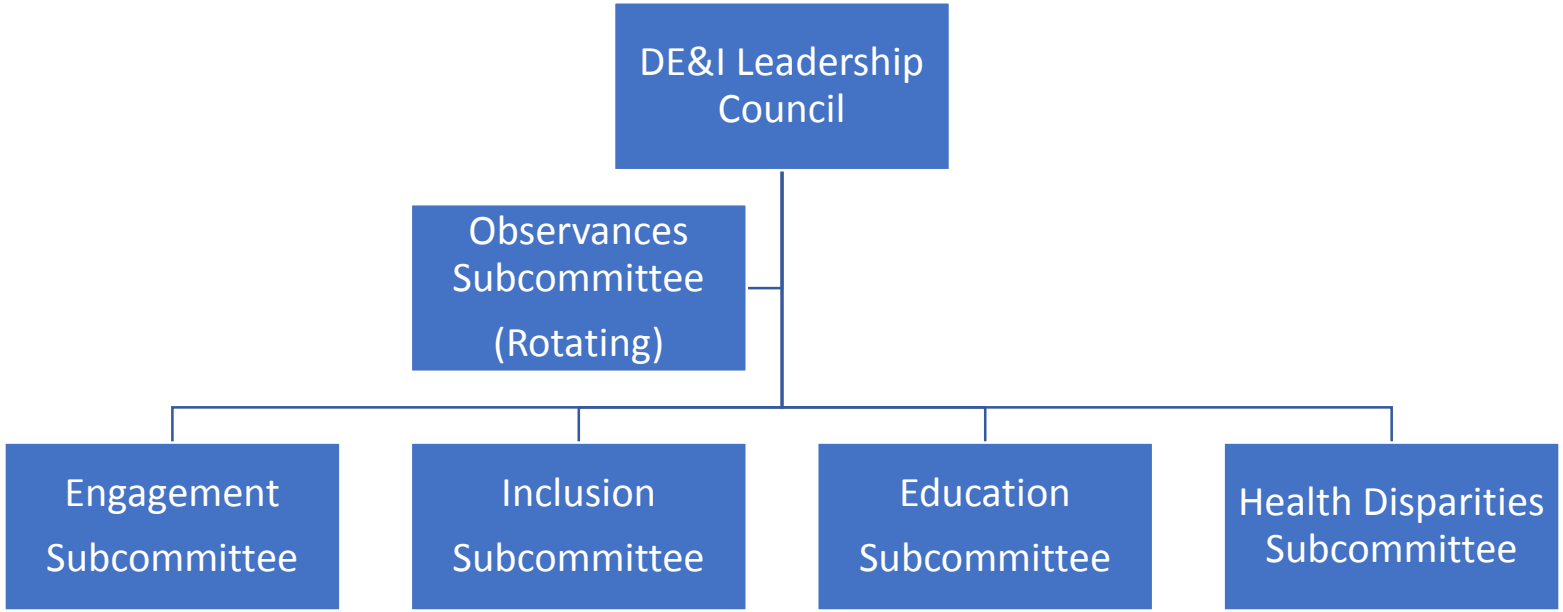
Objective 1	Objective 2	Objective 3
Provide opportunities for mentorship	Educate employees and team leaders on significance of Individual Development Plans	Review and support external recruiting effort

Strategic Goal 4

Goal 4: Support BCBSAZ effort in addressing health disparities.

Objective 1	Objective 2
Identify the depth and breadth of the problem	Connect with and support the efforts of the Foundation and Stakeholders

DEI Council Structure



The ELT Pledge

Listen More

- Affinity Groups
- DEILC SharePoint
- Employee Surveys

Professional Dev.

- Minority Mentorship
- Boosting IDPs

Hiring & Promotion

- Review of Recruitment Strategy
- Social Media Strategy

Procurement

- BCBSAZ Diversity Supplier Program
- Joining PSMSDC

Investing in Minority Education

- Empowering Diversity Scholarship
- BCBSAZ Minority Business Insurance Initiative

DEI Council Accomplishments

- DEILC Structure and Strategic Plan
- Launch of Affinity Groups
- Conversation Cafes
- Hispanic Issues Panel
- Partnership with the Diversity Supplier Program
- Hispanic Chamber of Commerce Insurance Initiative

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Provider Resources

Jadelyn Fields, Network Provider Service Manager and Educator

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AHCCCS Minimum Sub-Contractor Provisions – 10/01/2021

Effective 10/01/2021 AHCCCS has made an update to the Minimum Subcontract Provisions (MSPs). The MSPs are referenced and incorporated into the AHCCCS Provider Participation Agreement, Provider Contracts and the Health Choice Arizona Provider Manual, Chapter 3.

All AHCCCS providers are required to comply with the MSPs.

In addition to general corrections to citations throughout, the following revisions have been incorporated:

- Revised Fraud and Abuse section to clarify language regarding recoupments

MSPs are available here:
https://azahcccs.gov/PlansProviders/HealthPlans/minimumsubcontractprovisions.html

Health Choice Arizona and Health Choice Pathway Prior Authorization Updates Effective 10/01/2021

NOTICE: Prior Authorization Grid Updates for Health Choice Arizona and Health Choice Pathway

September 1, 2021

Dear Provider,

Effective 10/1/2021, the following codes will require prior authorization:

Applies to Health Choice Arizona (HCA) and Health Choice Pathway (HCP)	
Medical	K1006, K1007, K1009, K1015, K1016, K1018, K1020, 81278, 81279, 81518
Skin Substitute Codes	All Skin Substitute Codes require auth (Q4100 – Q4255)
Medical Pharmacy	J9314, Q5123, J0224, J9353, J9348, J7168, J1951, J1427, J1554, J9037, J9349, Q2053, Q9991

Reminder: All out of network providers will require Prior Authorization for all services

NOTICE: Preferred Skin Substitute Products

September 2, 2021

Dear Provider,

In our efforts to ensure the provision of quality care and as required by AHCCCS, Health Choice Arizona r
the use of preferred skin substitute products.

A request for a non-preferred product will require documentation supporting why a preferred product is
option. All products listed below require prior authorization.

Effective 10/1/2021, the following skin substitute products **will be preferred:**

Applies to Health Choice Arizona (HCA)	
Q4100	Skin substitute Not Otherwise Specified (for SomaGen only)
Q4101	Apligraf, per sq cm
Q4105	Integra dermal regeneration template (DRT) or Integra Omnigraft dermal regeneration matrix, per sq cm
Q4106	Dermagraft, per sq cm
Q4110	PriMatrix, per sq cm PrMatrix AG and PriMatrix AG Fenestrated Primatrix AG Meshed Primatrix Meshed and Primatrix Fenestrated
Q4121	TheraSkin, per sq cm
Q4128	FlexHD, AllopatchHD, or Matrix HD, per sq cm
Q4137	AmnioExcel, AmnioExcel Plus or BioDExcel, per sq
Q4151	AmnioBand or Guardian, per sq cm
Q4158	Kerecis Omega3, per sq cm
Q4166	Cytal, per sq cm
Q4168	AmnioBand, 1 mg
Q4197	PuraPly XT, per sq cm

Effective 10/1/2021, all other skin substitute products not listed above **will be considered non-preferred**.

Arizona Association of Health Plans (AzAHP) Update

The AHCCCS Credentialing Alliance has made enhancements to the AzAHP forms for 2021. The AzAHP form in addition to a current CAQH is required for all initial credentialing.

The newest version of the forms will help ensure those providers requiring temporary credentialing are processed in a timely manner.

The credentialing team has begun using the 2021 revision of the form on August 4, 2021.

Previous versions of this form will not be accepted after October 31, 2021.

Important

A delay in processing of your credentialing application may occur if older versions of the AzAHP are used.

- The most current version may be found on our website at: https://www.healthchoiceaz.com/providers/forms/ under "Request for Participation".
  - A delay in processing will occur if your CAQH application is not currently attested, information is omitted and/or if disclosure questions are answered erroneously.

Claim Submissions

KEEP YOUR RECORDS UP TO DATE!

By not keeping your information current, you may experience claim rejections, non-payments, or returned check payments.

All providers are recommended to submit claims/encounters electronically. Electronic billing ensures faster processing and payment of claims, eliminates the cost of sending paper claims, allows tracking of each claim/encounter sent, and minimizes clerical data entry errors.

Health Choice Arizona (AHCCCS)

Health Choice **Arizona Payer ID# 62179**

P.O. BOX 52033, PHOENIX, AZ 85072-2033

Health Choice Pathway (Medicare Advantage)

Health Choice **Pathway Payer ID# 62180**

P.O. BOX 52033, PHOENIX, AZ 85072-2033

Claim Submission Reminders

KEEP YOUR RECORDS UP TO DATE!

By not keeping your information current, you may experience claim rejections, non-payments, or returned check payments.

No Staple Required

Please do not staple documents or claims. If there is a document being submitted with the claim, the document should lay directly behind the claim and each page of documentation should indicate the claim number.

Prior Authorization Number

Submit claims with the full and complete Prior Authorization number reported, including leading zeros.

Sending Documentation to a specific department?

Help us stay efficient in getting your mail to the correct department, please indicate which Department your mail should be directed to:

Health Choice Arizona OR Health Choice Pathway,

Attention: SPECIFIC DEPARTMENT,

410 N. 44th Street, Suite #900

PHOENIX, AZ 85008

PROVIDER PORTAL

Are you registered for the Provider Portal?

Sign-up today!

Get access to secure member eligibility, claim status/reconsideration, submit medical and pharmacy prior authorization requests and much more.

!!!COMING SOON!!!

Provider Announcements (MOC, Portal Maintenance)

Alerts (Admission/Discharge)

Online AzAHP

Our portal is available under the 'Providers' tab of each of our plan websites:

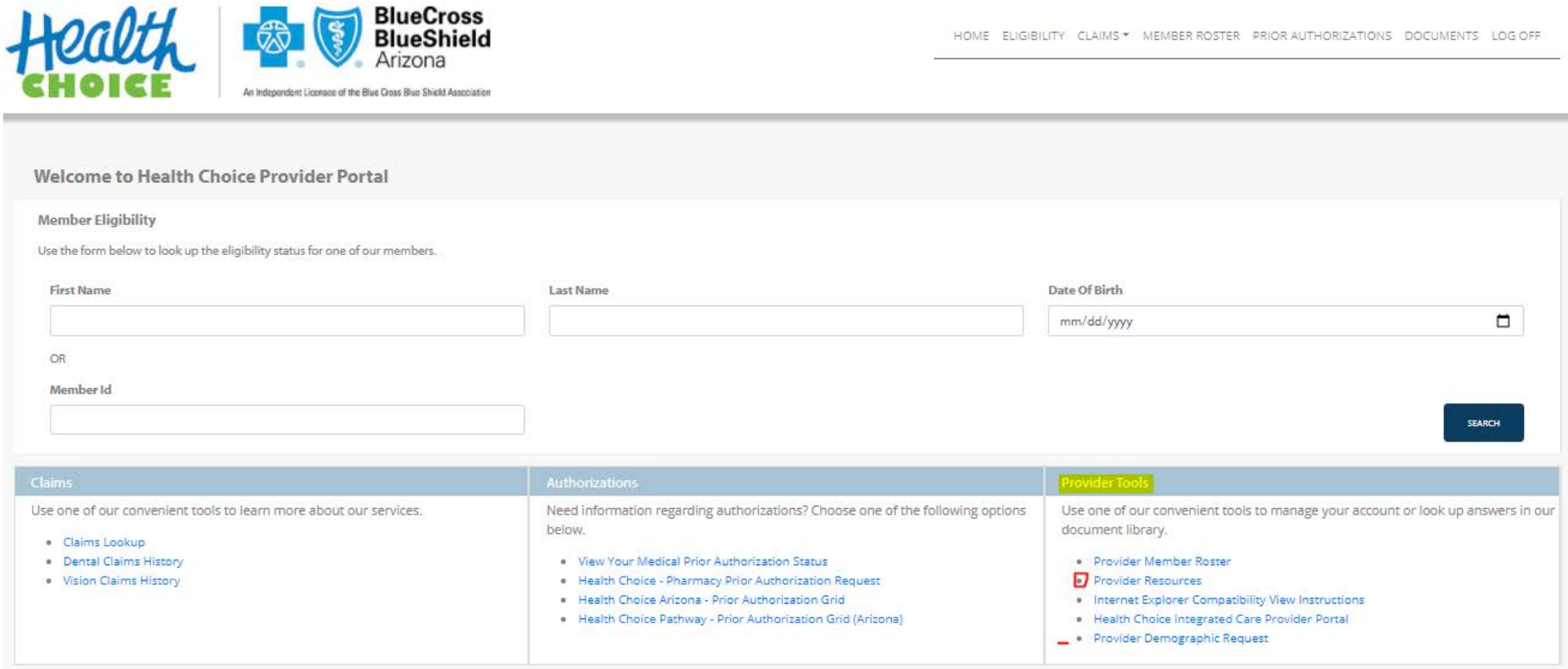
www.healthchoiceaz.com

www.healthchoicepathway.com

Easy to follow portal training video(s) on our websites

'Providers' tab -> 'Provider Education'

Secure Provider Portal View



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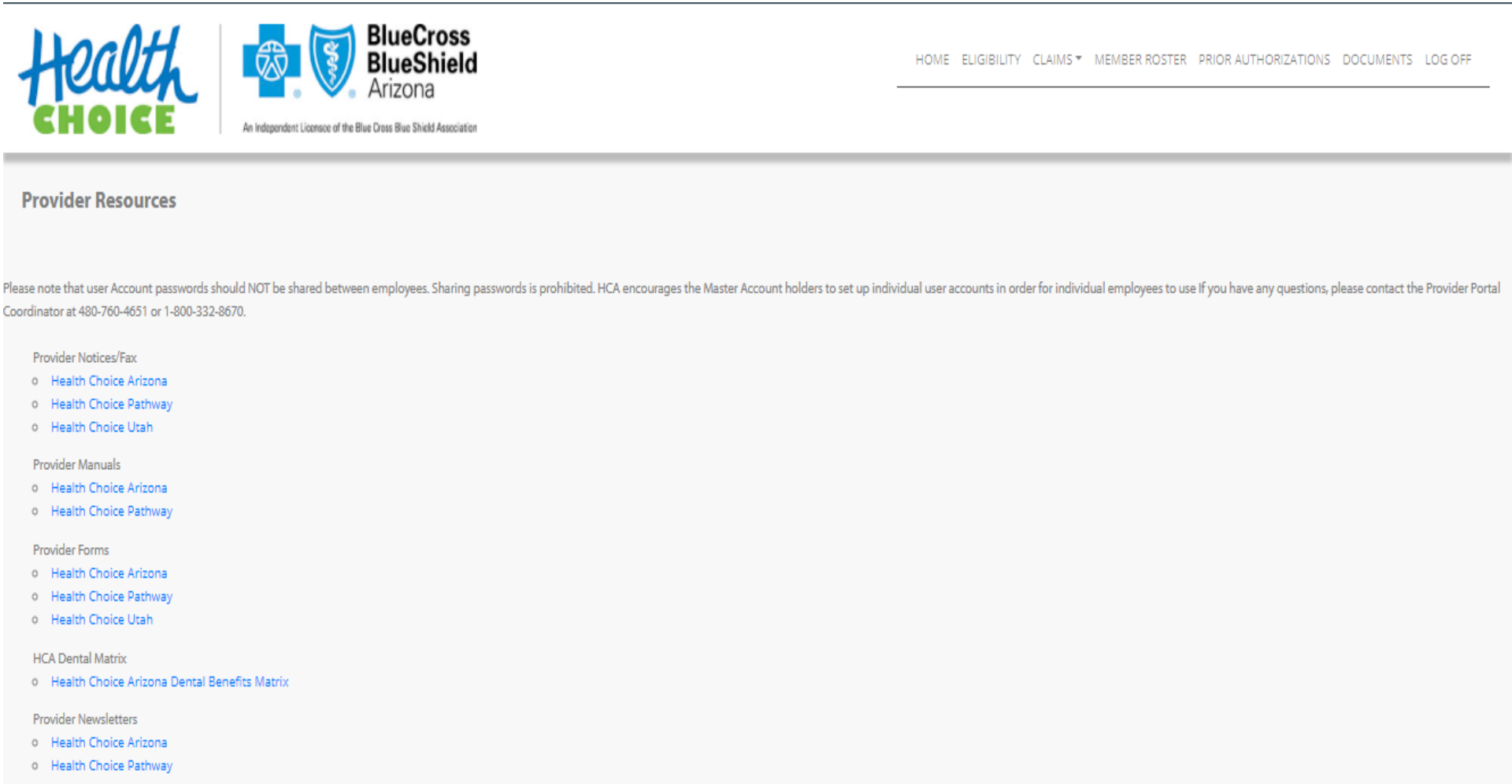
Online Provider Resources
Secure Provider Portal View



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Online Provider Resources & Education Material

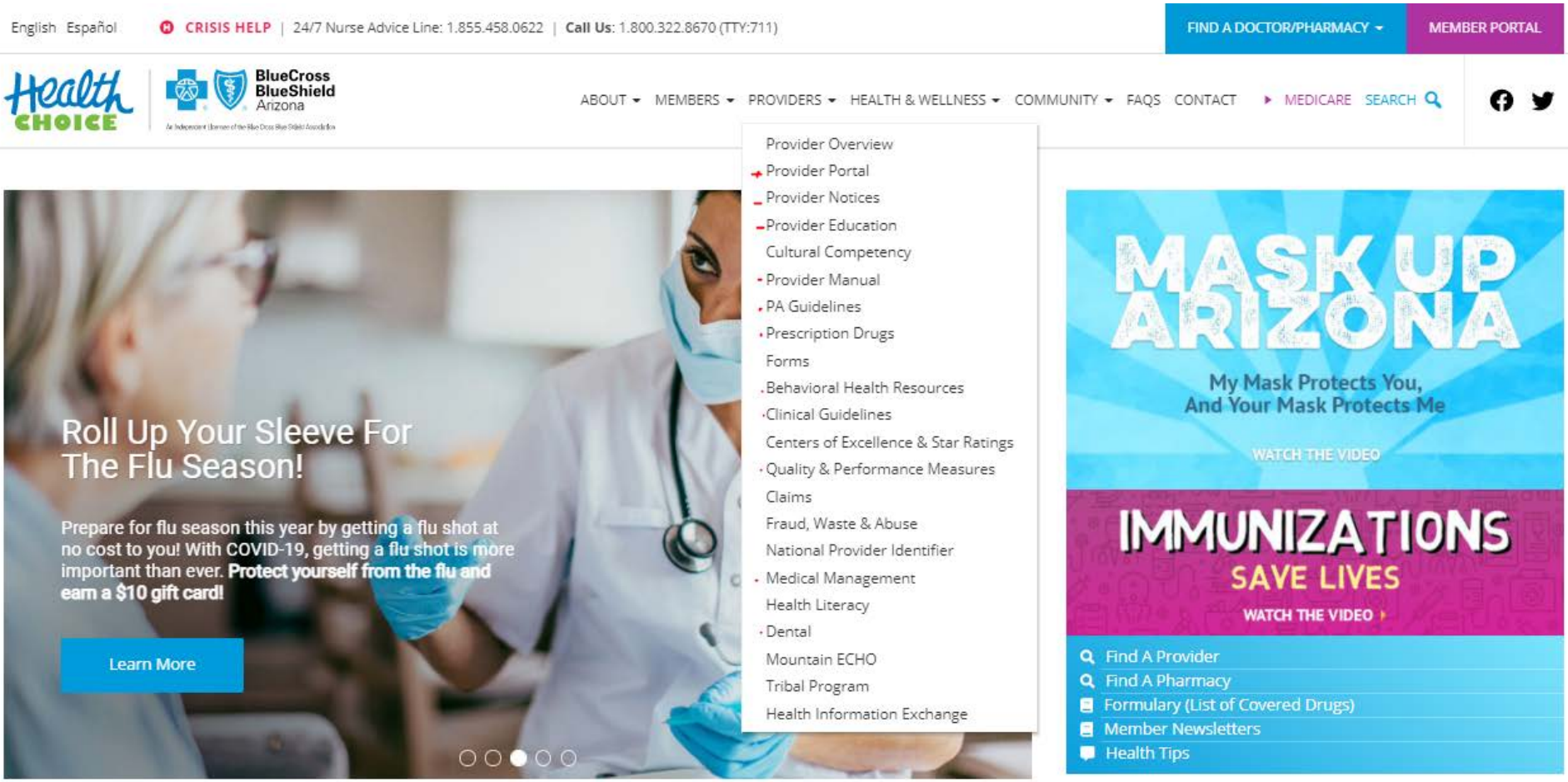
Visit us Online!

Health Choice Arizona:
www.healthchoiceaz.com/

Health Choice Pathway:
www.healthchoicepathway.com/

- **Provider Manual(s)**
- **Important Notices – Announcements**
- **Prior Authorization Grid(s)**
- **Clinical Guidelines**
- **Prescription Drug Formulary**
- **Provider Education Resources**
  - Provider Newsletters
  - Behavioral Health Services
  - Dental Services
  - Member Management Programs

Our Public Website
Online Provider Resources



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Provider Newsletter

May - June 2021

Health CHOICE

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AHCCCS Electronic Visit Verification (EVV)

To support your EVV onboarding efforts, AHCCCS has compiled several updates and reminders. We appreciate your willingness to work with AHCCCS over the past many months to prepare and initiate implementation of EVV.

Claims and Policy Grace Period – Continued

At this time, AHCCCS is seeking further guidance from the Centers for Medicare and Medicaid Services (CMS) that will inform a decision on the new date the hard claim edits will begin.

Stay Informed

Please sign up for the AHCCCS Constant Contact email list to receive any and all EVV notices like this one from AHCCCS under the "Stay Informed" tab on the AHCCCS website www.azahcccs.gov/EVV

AHCCCS Electronic Visit Verification (EVV)

This extension does not mean that providers can wait to start EVV

Compliance with EVV was required beginning January 1, 2021. Providers should use this period to develop operational procedures, train administrative personnel, onboard members, and caregivers and self-monitor agency compliance in order to avoid billing challenges when the hard claim edit period begins.

Once the hard claim edits begin, providers will not get paid unless all the required EVV visit data is present.

In partnership with Sandata, AHCCCS will be periodically posting "quick tips" to help providers using the Sandata system. The first in the installment is a "quick tip" to help providers understand and resolve clients showing up in a pending status. Quick tips are now available on the AHCCCS website under the Sandata EVV System Resources and Technical Assistance tab.

For more questions about billing, please reference the Billing FAQ on the EVV webpage (www.azahcccs.gov/EVV).

AHCCCS AMPM, ACOM & Coding Updates

!STAY UP TO DATE!

Updates to the AHCCCS Medical Policy Manual (AMPM) , AHCCCS Contractor Operations Manual (ACOM), and Medical Coding Resources are available on the AHCCCS website.

The AHCCCS Medical Coding Unit is responsible for the update and maintenance of all medical coding related to AHCCCS claims and encounters processing. This includes place of service, modifiers, new procedure codes, new diagnoses, and coding rules. This unit is also responsible for reviewing and responding to any medical coding related guidelines or questions. This includes questions related to daily limits, procedure coverage, etc.

Please also visit the AHCCCS Encounters Resource page for additional resource and guidance regarding coding and plan coverage updates.

Translation Services: What are the provider responsibilities?

Determine

- The languages spoken by their patients
- Qualified staff or vendor to provide these services
- The costs that your office will incur as a result of your contract (budget)

Train

- Staff on how to schedule interpretation services

Gain

- Feedback on effectiveness or needs

Make

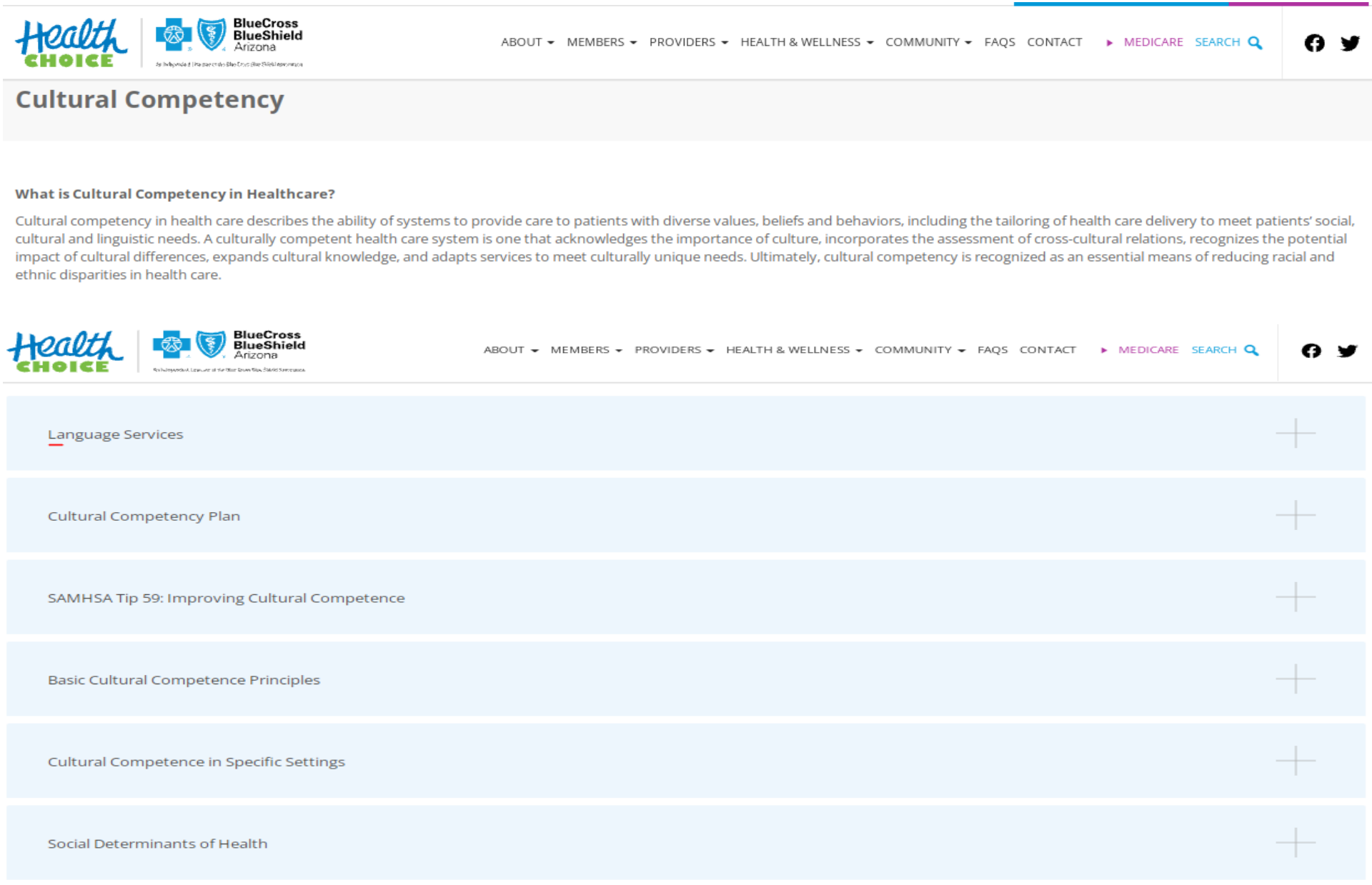
- Changes as needed

Reach out

- Health Choice Cultural Competency Administrator Jeanette Mallery with questions, concerns and support Culture@healthchoiceaz.com

Provider Resources: Translation Services

https://www.healthchoiceaz.com/providers/cultural-competency/



Q & A

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