

Marketplace, BlueCard and Kansas Provider Networks

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This document provides an overview of the Kansas Provider Networks, the Kansas products sold on and off the Health Insurance Marketplace and information on the BlueCard® network. The information is intended to assist providers and their office staff with changes in the new marketplaces brought about by the Affordable Care Act.



**BlueCross
BlueShield
of Kansas**

An independent licensee of the Blue Cross Blue Shield Association.

Blue Cross and Blue Shield of Kansas, Inc.
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Marketplace Background

The Patient Protection and Affordable Care Act (ACA) of 2010 provides for the establishment of health insurance exchanges in each state. In Kansas, there is a federally facilitated exchange marketed as the Health Insurance Marketplace. The purpose of the Marketplace, or exchange, is to allow individual consumers to purchase qualified coverage during an open enrollment period of November 1, 2016 through January 31, 2017. Plans purchased by December 15, 2016 will be effective January 1, 2017. Small business owners will be able to purchase coverage for their employees through the Small Business Health Options Program (SHOP), which will be open year round.

The Marketplace and SHOPS will be internet websites through which eligible consumers may purchase insurance. They are intended to create a more organized and competitive platform for health insurance by offering consumers a choice of health insurance plans, establishing common rules regarding the offering and pricing of insurance, and providing information to help consumers better understand the options available. The Marketplace and SHOP promise to enhance competition in the health insurance market, improve choice of affordable health insurance and give individuals and small businesses purchasing power comparable to that of large businesses.

Health Insurance Marketplaces

The Health Insurance Marketplace and SHOPS are expected to offer consumers a variety of health insurance plans. Product and plan information, such as covered services and cost sharing (i.e. deductibles, coinsurance or copayments, and out-of-pocket limits) will be organized in a manner that will make comparisons across health insurance plans easier for consumers. In conjunction with offering a choice of health insurance plans, the Marketplace is intended to provide consumers with transparent information about health insurance plan provisions such as premium costs and covered benefits, as well as the issuer's performance in encouraging wellness, managing chronic illnesses and improving consumer satisfaction.

Blue Plans that offer products on the Marketplace and SHOP have collaborated with the state and federal governments for eligibility, enrollment, reconciliation and other operations to ensure consumers can seamlessly enroll in individual and employer-sponsored health insurance products. Kansas has a federally facilitated/state partnership Marketplace, which can be found at healthcare.gov. Information about the Marketplace can be found at: <http://www.bcbsks.com/HealthPlans/Under65/index.htm>.

Health Plan Accreditation

Insurance companies selling products in the Marketplace must have achieved health plan accreditation through an approved accrediting entity. Blue Cross and Blue Shield of Kansas (BCBSKS) chose URAC as our accrediting organization because our case management and disease management programs have been accredited since 2011. The utilization management program also is URAC accredited and is now a component of Health Plan Accreditation.



In 2014, BCBSKS earned URAC's Full Health Plan Accreditation for commercial (off Marketplace) products, as well as products sold on the Marketplace. BCBSKS also earned full accreditation for a commercial product known as BlueCross BlueShield Solutions, Inc., a health maintenance organization (HMO) product with in-network and emergency services only benefits (see Pages 8 and 9 for more details). On-Marketplace Solutions products became fully accredited in October 2015.

In addition, BCBSKS received Qualified Health Plan (QHP) status from the U.S. Department of Health and Human Services, which is the gold seal approval to sell health insurance products on the Marketplace.

BlueCard for Public Marketplaces Products

The Blue Cross and Blue Shield Association (Association) has worked closely with the Blue plans during the years to develop the BlueCard networks that are available to members with out-of-area benefits we refer to as BlueCard PPO.



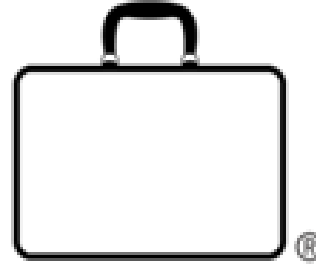
The enhanced BlueCard program is being referred to as the **BlueCard PPO Basic Program**. However, the term will not be used for marketing purposes but instead for provider education materials and within the Blue System. There will be new ID card suitcase logos identifying the member's access to the National Qualified PPO network applicable to the member coverage.

Health Identification Card and Logos

Blue Plan Member ID Cards

The Association has created a Quick Guide to BCBS Member ID Cards for use by provider offices. When Blue plan members arrive at your office or facility, remember to ask to see their current member identification cards at each visit. This will help you to identify the product the member has, to obtain health issuer contact information and to assist with claims processing. For more information regarding the member ID cards, please read the Quick Guide to BCBS Member ID Cards, a document compiled by the Association.

BlueCard Suitcase Logos

Logo	Description	Networks	Product Description
	<p>The “PPOB in a suitcase” logo on the front of a member’s ID card means the member has selected a PPO product and the member has access to a new PPO network, referred to as BlueCard PPO Basic.</p>	<ul style="list-style-type: none"> • BlueCAP • Preferred Care Blue (Kansas City’s network) 	<ul style="list-style-type: none"> • Individual • SHOP
	<p>The “PPO in a suitcase” logo on the front of the member’s ID card means the member has PPO or EPO type benefits available for medical services received within or outside of the United States. It also means the provider will be reimbursed for covered services in accordance with the provider’s PPO contract with the local Blue Plan. These products are purchased off the Marketplace.</p>	<ul style="list-style-type: none"> • Blue Choice • Preferred Care Blue (Kansas City’s network) 	<ul style="list-style-type: none"> • Individual • Small Group
	<p>An empty suitcase logo on the front of a member’s ID card signifies the member has out-of-area coverage that is not a PPO product. These products can be purchased on or off the Marketplace.</p>	<ul style="list-style-type: none"> • Limited benefit products 	<ul style="list-style-type: none"> • Individual • Small Group • SHOP • Solutions

Kansas Provider Networks and Contracts

BCBSKS provider network contracts are established by a base contract referred to as the Competitive Allowance Program (CAP). Separate contracts for professional and institutional providers are offered to providers as defined below.

Competitive Allowance Program (CAP) contracts are offered to eligible professional, ancillary and facility providers located in the BCBSKS service area, which includes all Kansas counties except Johnson and Wyandotte (note: BCBSKS does have a CAP dental network in the Greater Kansas City area). Provider types that require credentialing will be offered network participation following the credential committee decision.

Blue Choice is a hospital PPO network. Hospitals and Ambulatory Surgery Centers that have signed a Blue Choice agreement have agreed to lower reimbursement than the CAP agreement. Ancillary and professional providers who have signed a CAP agreement are automatically enrolled in the Blue Choice PPO Network and receive the same CAP reimbursement.

BlueCAP is the network that represents all providers enrolled in Blue Choice and is the network used for the health insurance exchange.

Solutions, Inc. is the network that represents all providers enrolled in Blue Choice. Solutions products have only in-network and emergency benefits.

Plan 65-Select is a supplemental Medicare contract that requires the hospital to write-off the inpatient deductible. Participation is voluntary with the desire for one hospital per designated county participating in Plan 65-Select.

Value Blue is a network of providers who have agreed to accept 50 percent of the BlueChoice network reimbursement.

Provider Directories

Members will automatically be directed to Blue providers in BlueCard PPO Basic, BlueCard PPO or BlueCard Traditional networks by typing in their prefix into the National Doctor and Hospital Finder website, mobile version or mobile app, or by providing the prefix when calling the BlueCard Access Call Center.

NOTE — The National Doctor and Hospital Finder website will be replaced by Vitals website in early 2017.

2017 BCBSKS Product Offerings

BCBSKS is offering benefit plans for Kansas consumers to have the option of purchasing coverage through the Marketplace or directly from BCBSKS. The various plans offer different levels of benefits and pricing to meet individual needs.

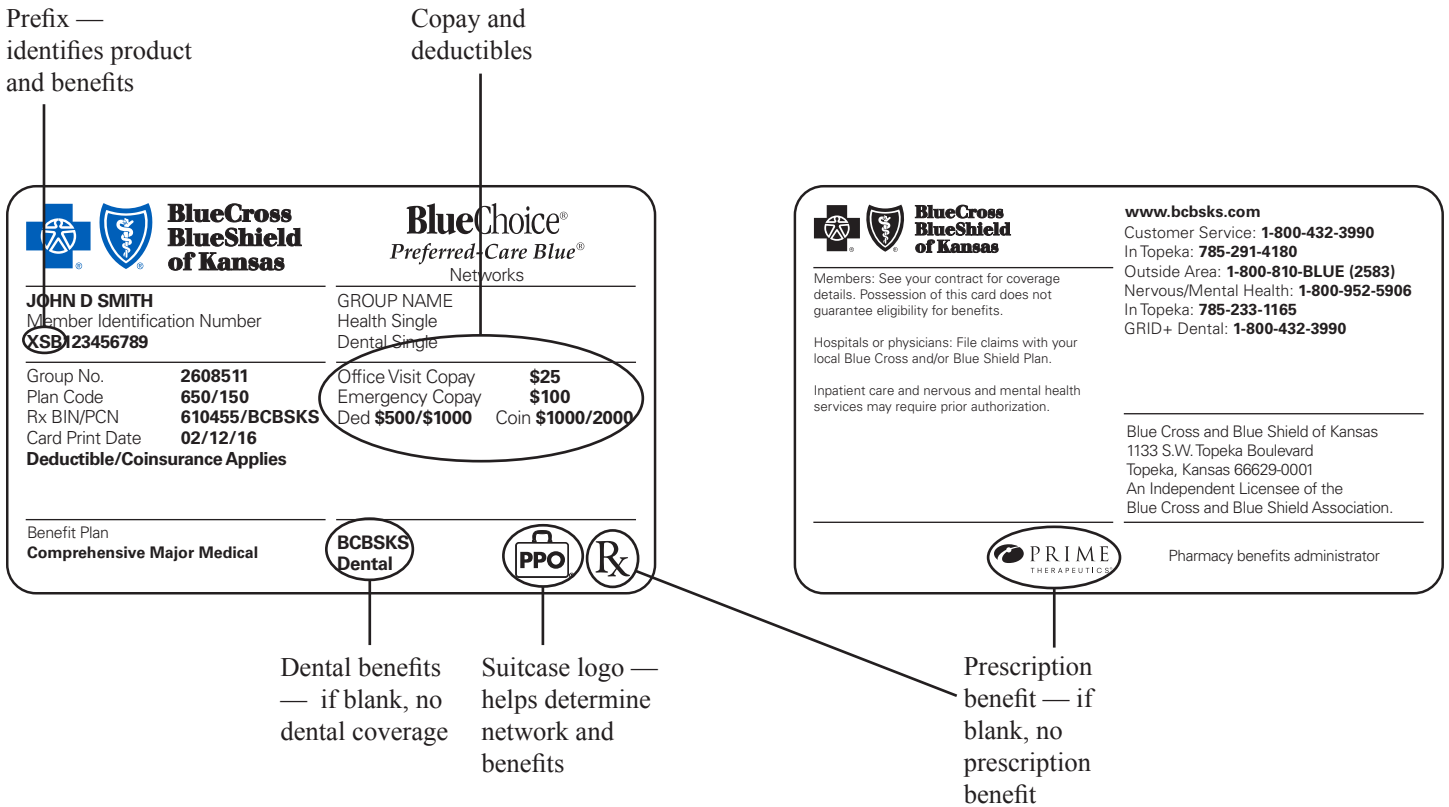
BCBSKS Member ID Card Prefixes

The ID card prefixes for BCBSKS members purchasing products on or off the Marketplace are listed below and effective January 1, 2017.

Prefix	Network and Product Description
XSB	Blue Choice Small Group off Marketplace
XST	Blue Choice Individual off Marketplace
XSJ	BlueCAP—SHOP
XSC	Solutions—Individual on Marketplace
XSG	Solutions—SHOP on Marketplace
XSQ	Solutions—Individual off Marketplace
XSR	Solutions—Small Group off Marketplace

Preferred Care Blue on KS Member ID Cards

- Preferred Care Blue (Kansas City’s network) will be on the ID cards for base plans with Blue Choice and BlueCAP (PPOB—Marketplace network).
- Preferred Care Blue will not be on the ID cards for the limited network plans. These cards will have Blue Choice and BlueCAP.



BlueCross BlueShield Solutions, Inc.

Since 2015, Blue Cross and Blue Shield of Kansas has been offering BlueCross BlueShield Kansas Solutions, Inc., an HMO and a wholly owned, branded subsidiary of BCBSKS.

Although a separate company, Solutions functional tasks are handled by existing BCBSKS staff. Solutions Inc. provides BCBSKS with more product-offering flexibility on and off the Marketplace. The products do not have capitation or gatekeeper aspects of an HMO while providing the opportunity to develop benefits for exclusive networks and more flexibility with out-of-network benefit design.

HMO differences from PPO

HMO products are different than PPO products in Kansas. PPO products cannot vary more than 30 percent of the actuarial value between in- and out-of-network benefits. HMO products are not limited to the 30 percent differential between in- and out-of-network benefits. Out-of-network services can be classified as not covered except in some instances (i.e. emergency services, services not provided in the network, etc.).

Solutions on and off the Marketplace

These HMO products are available for the individual (on and off the Marketplace) and small group (on and off SHOP) markets.

Solutions Metallic Benefits

The 2017 Metallic Benefits for Solutions will include two bronze and two silver on the Marketplace, and two bronze, two silver, and one gold plan available off the Marketplace. These plans have no benefits for services received outside of the BCBSKS service area. Members seeking out-of-plan-area services need to contact Customer Service to determine coverage for out-of-area service. An out-of-plan-area emergency service or an inpatient admission within 24 hours of the emergency service shall be covered.

Prime Specialty Pharmacy is the exclusive specialty pharmacy for all metallic plans.

Remittance Advice

Claims for Solutions members will be remitted to providers on a co-branded BCBSKS and Solutions remittance advice. A separate Solutions check will be cut and mailed with the co-branded remittance advice or sent EFT at the provider's request. Providers who receive electronic remits (835) will receive a separate remittance Solutions file.

Provider Network

Professional providers who are CAP contracted also are BlueChoice and Solutions contracted. When admitting a Solutions patient to a hospital, providers are asked to confirm the admitting hospital is in the BlueChoice Hospital network to protect the member from any out-of-network charges. Contracting providers with BCBSKS/BlueChoice will receive the same reimbursement for services provided to Solutions members as they do for all BCBSKS members. No additional contracting is necessary.

2017 Solutions Member ID Card Examples

Notice the empty suitcase logo in the bottom right corner of the front side of the card. The empty suitcase logo signifies the member has out-of-area coverage for emergency services or services not provided in network.

The Solutions ID card for members who purchase health benefits only will have only the Solutions logo. Members who purchase Solutions health and BCBSKS dental will have both logos on the ID card.

Prefix — identifies product and benefits

Copay and deductibles

BlueChoice[®] SolutionsChoice Networks

JOHN D SMITH
Identification Number
XSQ123456789



Group No. **714553005**
Plan Code **650/150**
Rx BIN/PCN **610455/BCBSKS**
Card Print Date **12/15/15**
Deductible/Coinsurance Applies

Non-Group Health Individual Dental Individual

Office Visit Copay **\$35**
Specialist Copay **\$70**
Ded. **\$3000** Coin. **80%**

No Out-of-Network Benefits (see back of card for exceptions)

Benefit Plan
BlueCare Solutions Silver Ch

BCBSKS DentalPlus  

BlueCross BlueShield Kansas Solutions

www.bcbsks.com
Customer Service: **1-800-392-7366**
In Topeka: **785-291-4186**
Outside Area: **1-800-810-BLUE (2583)**
Nervous/Mental Health: **1-800-952-5906**
In Topeka: **785-233-1165**
GRID+ Dental: **1-800-432-3990**

Members: See your contract for coverage details. Possession of this card does not guarantee eligibility for benefits.

Hospitals or physicians: File claims with your local Blue Cross and/or Blue Shield Plan.

Inpatient care and nervous and mental health services may require prior authorization.

No benefits for out-of-network services are available, except services for Medical Emergencies and covered services not available in-network. See your certificate for details.

BlueCross BlueShield Kansas Solutions/
Blue Cross and Blue Shield of Kansas
1133 S.W. Topeka Boulevard
Topeka, Kansas 66629-0001
Independent Licensees of the
Blue Cross and Blue Shield Association.

 Pharmacy benefits administrator

Dental benefits — if blank, no dental coverage

Suitcase logo — helps determine network and benefits

Prescription benefit — if blank, no prescription benefit

BlueChoice[®] SolutionsCap Networks

JOHN D SMITH
Identification Number
XSC123456789



Group No. **714553005**
Plan Code **650/150**
Rx BIN/PCN **610455/BCBSKS**
Card Print Date **02/18/16**
Deductible/Coinsurance Applies

Non-Group Health Individual

Office Visit Copay **\$25**
Specialist Copay **\$50**
Emergency Copay **\$300**
Ded. **\$1500** Coin. **80%**

No Out-of-Network Benefits (see back of card for exceptions)

Benefit Plan
BlueCare Solutions Gold

The absence of the BCBSKS logo and dental language at the bottom indicates no dental coverage.

Claims Filing and Other Procedures

Marketplace Individual Grace Period

The ACA mandates a three-month grace period for individual members who receive a premium subsidy from the government and are delinquent in paying their portion of premiums. The grace period applies as long as the individual has previously paid at least one month's premium within the benefit year. BCBSKS will pend claims the second and third month of the grace period when payment has not been received. Providers will be notified by letter when a member's claims have been pended for non-payment of premium. When premium payment is received the pended claims will be processed. In the event of non-payment of premiums, the pended claims will be denied no coverage and the provider will be notified on their remittance advice. During the three-month grace period, providers may not bill the member. After the three-month grace period and notice from BCBSKS through the remittance advice that coverage has been canceled, the provider may bill the member for the services not paid during the second and third month of the grace period.

The ACA grace period also applies to policies bought on the SHOP for small groups. However, the ACA grace period for members of a SHOP policy is only 31 days, rather than 90 days. BCBSKS will suspend claims during this 31-day grace period.

Referring Provider Required on Claims for Indian Health (Native American) Services

As of January 1, 2014 under the ACA, insurers covering Native Americans who meet defined financial criteria are prohibited from applying cost sharing for items or services furnished directly by an Indian Health Service (IHS), an Indian tribe, tribal organization or urban Indian organization, or through a referral.

To administer benefits correctly for the Native American population, the treating provider must include the referring provider name and NPI when submitting a claim for services provided to an insured Native American, when these members present their paperwork to the provider.

The referring provider's name and NPI is submitted in the 2310A (claim level) and/or 2420F (line level) electronically, or on paper in box 17 and 17b when submitting the claim.

Commercial Risk Adjustment

The ACA created a guarantee issue environment beginning January 1, 2014, for the individual and small group markets. This means there will be no health histories to fill out as part of applying for health insurance coverage and all eligible applicants will be approved for coverage regardless of their past or current health conditions during open enrollment periods or when they have a qualified triggering event. The ACA incorporated a process called commercial risk adjustment (CRA) designed to encourage issuers to compete on premium, efficiency and quality. An issuer's risk adjustment is calculated based on the average of each member's risk scores (estimate of a person's anticipated health care costs). The government will monitor which issuers have low-risk enrolled populations and those with high-risk enrollment. Based on the issuer's risk score, there will be a shift of funds from low-risk to high-risk issuers to offset the cost of care for the high-risk population insured by the issuer with the high-risk score.

The risk adjustment scores for those insured, as well as issuers, and the shifting of funds needs to be managed in a manner that is fair and equitable to all. The risk scores calculated by the issuer for each of its members is based on the member's age/gender, plan selection and ICD diagnosis codes submitted on the claim or extracted directly from the medical record. The risk adjustment calculations are based on claims data in a current year. Diagnosis coding is the primary indicator for risk adjustment calculation and auditing. When a claim record does not equal the clinical reality of the patient's overall health, this creates a gap in risk score calculations. Diagnosis specificity is critical for an issuer to manage its risk adjustment score.

Risk Adjustment Data Validation Audit

Risk adjustment calculations are based on claims data in a current year as referenced above. In order for an issuer to maintain or improve its overall risk adjustment score, validating the diagnosis codes submitted on the claim to the medical record documentation is essential.

The U.S. Department of Health and Human Services requires issuers to conduct risk adjustment audits annually on 200 members. The audit requires the issuer to substantiate the diagnosis codes in the claims records by review of the actual medical documentation and identify any medical conditions that can be coded in addition to the codes on the claim. When diagnosis codes from claim submissions do not align with medical record documentation, CMS auditors use the medical record as the source of truth.

Provider education will occur in the instances where additional diagnosis codes were identified. The education is to encourage the level of diagnosis codes submitted on future claims to be those conditions present in the medical documentation. Annually, CMS will select 200 members and our Initial Validation Auditor (Altegra Health, subcontracting record retrieval to Datafied) will retrieve the medical records for the risk adjustment audit.

Verscend Medical Records Requests

Verscend has been selected to gather medical records on behalf of BCBSKS and other Blue Cross and/or Blue Shield companies. Blue plans use Verscend to retrieve medical records to support HEDIS, risk adjustment and government required programs related to the ACA.

Verscend is an experienced health care analytics and services company and best-in-class supplier. Verscend will provide an efficient centralized process to coordinate medical record requests from BlueCross and/or BlueShield companies across the country and help reduce multiple requests for patient data.

Effective medical record retrieval services play a fundamental role in driving optimal-quality reporting outcomes and ensuring appropriate risk scores.

All pertinent and complete medical records must be provided or made available by the contracting provider. This includes requests from Verscend. BCBSKS will not be able to assist with questions on the record requests and providers will need to work directly with Verscend with questions.

Records requested by Verscend may be submitted in the following ways:

- Via uploading the record's image to a secure portal at www.submitrecords.com; enter the secure password "bcbsa89" and select the files to be uploaded
- Via secure fax to 1-888-231-9601
- If the above options are not feasible for your office, please contact Verscend directly at 1-877-489-8437 to discuss retrieval options.

NOTE — BCBSKS may be requesting records directly from providers in addition to Verscend.

HIPAA/Privacy

Verscend is contractually bound to preserve the confidentiality of members' protected health information (PHI) obtained from medical records, in accordance with HIPAA regulations. Please note that patient-authorized information releases are not required in order for you to comply with these requests for medical records.

Providers are permitted to disclose PHI to issuers without authorization from the patient when both the provider and issuer had a relationship with the patient and the information relates to the relationship [45 CFR 164.506(c) (4)]. For more information regarding privacy rule language, please visit <http://www.hhs.gov/ocr/privacy>.