SOUTH DAKOTA
THIRD PARTY PAYER DAY

SEPTEMBER 12, 2017

PRESENTED BY

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Network Engagement Business Partners

VALUE INDEX SCORE (VIS)

VALUE INDEX SCORE NETWORK ROLL-OUT

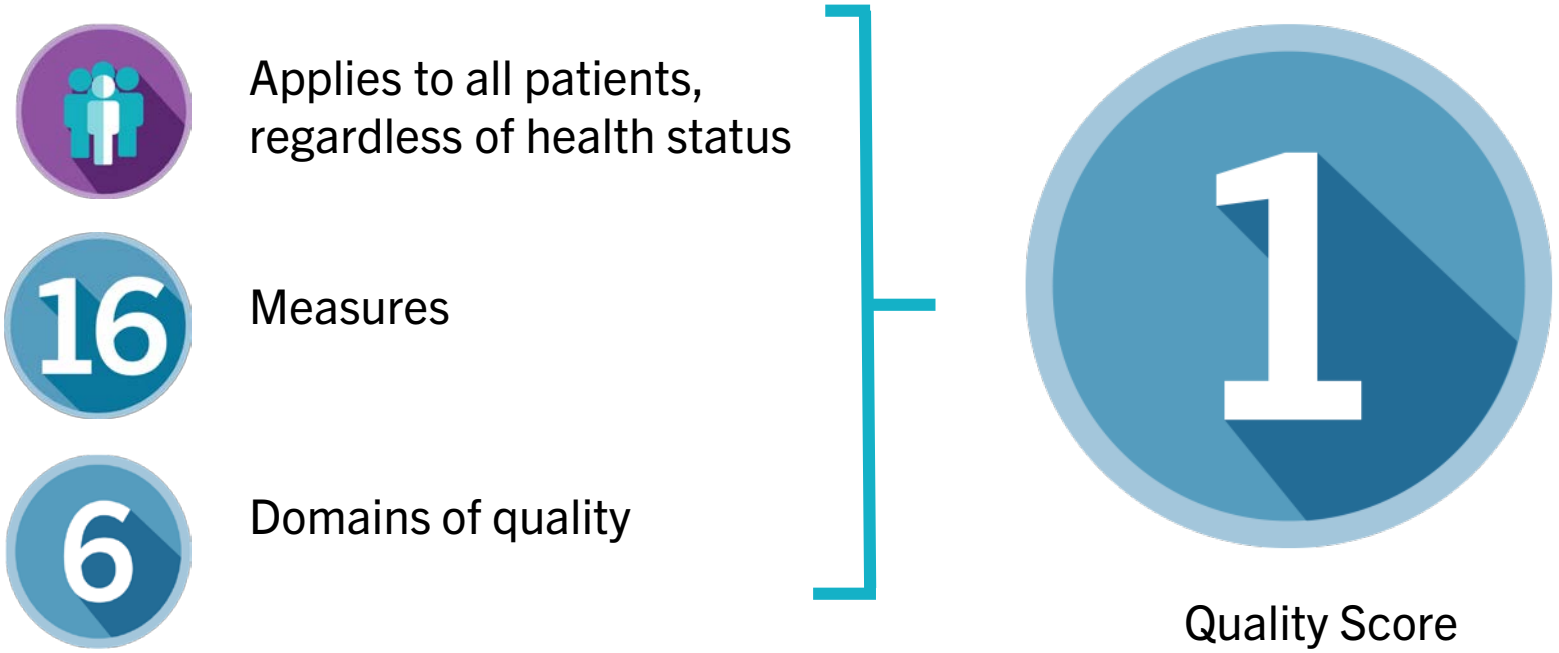
- Promoting transparency on quality and efficiency of care
- January 2017 – Wellmark ACO partners' primary care providers' VIS information presented to members on Wellmark's secure member website, *myWellmark*
- February 2017 – Written correspondence sent to network primary care providers from Wellmark's chief medical officer
- July 2017 – All network primary care providers' VIS information is accessible to members on *myWellmark*

MEASUREMENT DESIGN PRINCIPLES

- Meaningful to customers
- Population, not disease centric
- Meaningful impact on Triple AIM (cost, quality, patient experience)
- Can be influenced by provider intervention
- Supported by evidence
- Allows cross-physician comparison
- Supports continuous quality improvement
- Claims based, risk adjusted, reliable
- Minimizes administrative burden

VALUE INDEX SCORE (VIS)SM

Developed for Wellmark by 3M Health Information Systems, the VIS is a single score that quantifies the quality and efficiency of care — like a *Consumer Reports*® for health care value



VALUE INDEX SCORE

Domain	Definition	Measures
Primary and Secondary Prevention	Screening for early detection or prevention of disease	• Breast Cancer Screening • Colorectal Cancer Screening Index • Well-Child Visits for Infants • Well-Child Visits for Children 3-6 Years
Tertiary Prevention	Managing the level of urgency associated with member health issues	• Potentially Preventable Admissions (PPA) • Potentially Preventable ED Visits (PPV)
Panel Health Status Change	Managing the health status of members whose chronic conditions may progress	• Chronic Complexity Status Jumpers • Chronic Severity Jumpers
Continuity	Concentration and consistency of provider visits	• PCP Visit • Qualified Provider Visit • Continuity of Care Index
Chronic and Follow-Up Care	Provision of engagement and post-hospitalization care	• Potentially Preventable Readmissions (PPR) • Post-Discharge Follow-Up • Three Chronic Care Visits
Efficiency	Managing generic drug prescribing and the use of potentially non-essential ancillary services	• Generic Prescribing • Potentially Preventable Services (PPS)

WHO ARE POTENTIAL ATTRIBUTED MEMBERS?

IN	OUT
Fully Insured Members	Non-Participating Self-Funded and Blue Card Host Attributed Members
Participating Self-Funded Members	Wellmark Blue Rewards
Participating Blue Card Host Members	Wellmark Synergy Health
	Wellmark Value Health Plan
	Medicare-Related Products
	Federal Employees Plan
	Wellmark is not Primary Insurer
	Members with less than 12 member months

VIS PERFORMANCE RATES

VIS uses two types of performance rates:

- Percent completion (e.g., percent of well-child visits completed among eligible children)
- Percent different from expected (e.g., percentage difference in readmission rate from expected readmission rate)
    - (Observed Rate –Expected Rate) ÷ Expected Rate
    - Risk-adjusted Expected
- The VIS is updated monthly with the most recent rolling 12-months of data.

MINIMUM SCORING REQUIREMENTS

1. An attributed member must have 12 continuous months of coverage.
2. A measure must have 19 eligible members or 10 eligible members with group average imputation. A group is a Tax Identification Number.

   Potentially Preventable Readmissions must have 10 cases or 6 cases with group average imputation.

   Discharge follow-up must have 10 discharges or 6 discharges with group average imputation.
3. A domain score is available if a PCP has at least one measure scored in the domain.
4. A VIS score is available if a PCP has at least five domain scores.

TRANSPARENCY "TESTS"

The scoring process described above is used to provide real-time feedback for PCP performance. However, publicly-available scores undergo additional steps. All four "tests" below must be met for a PCP to have a publicly-available score.

1. A PCP must have a panel size of at least 50 members in the most recent reporting period. A reporting period is a rolling 12-months.
2. A PCP must have a score in the last three reporting periods.
3. The PCP scores in the last three reporting periods must differ by 0.45 or less.
4. If the difference is greater than 0.45, then the scores must be consistently increasing or decreasing. The consistency of change over the three periods is assessed by the statistic R2, the coefficient of determination. R2 is a measure of how closely points conform to a linear pattern, and ranges from zero to one, with R2=1 indicating a perfect line. Physicians with R2 > 0.80 are considered to have a consistent change in their VIS over the three reporting periods and are eligible for scoring.

TRANSPARENCY VIEW

Quality Score

Quality Score: 4.5

Use this score to see how well your personal doctor guides your care. The higher the number, the better the quality score.

Your health plan monitors how well doctors care for their patients across a number of different measures and then combines them into a single score for you.

TAKING ACTION

- Have your organization's designated security coordinator (DSC) assign the appropriate user role
  - Each TAX ID/individual provider NPI combination needs a login
- Review the weekly webinars April – May
- Access resources and tools to impact VIS
- Quality Transparency Provider Guide
- Sign up for Quality topic updates through WINS

WEBINARS

Series of webinars

- Program Overview
- Clinical Risk Groups
- Potentially Preventable Events
- Impacting the Value Index Score (VIS)

VIS SUPPORTING DOCUMENTATION

Webpage provides a one-stop shop for the Value Index Score and other initiatives. Log in to wellmark.com and click on Quality and Cost Transparency.

Provider Guide has been updated with a new Quality and Cost Transparency chapter.

Flier is a one-page Value Index Score overview.

Technical Guide provides a VIS general overview, methodology, measure thresholds and supporting documentation and evidence.

Measure Detail Guide includes the code details for each VIS measure.

PCP VIS Summary Report and data dictionary contains the current score for all 16 measures compared to the overall target. It is updated monthly.

Care Management Gap Report and data dictionary assists the PCP in understanding gaps in care for all 16 measures. It is updated monthly.

FAQ

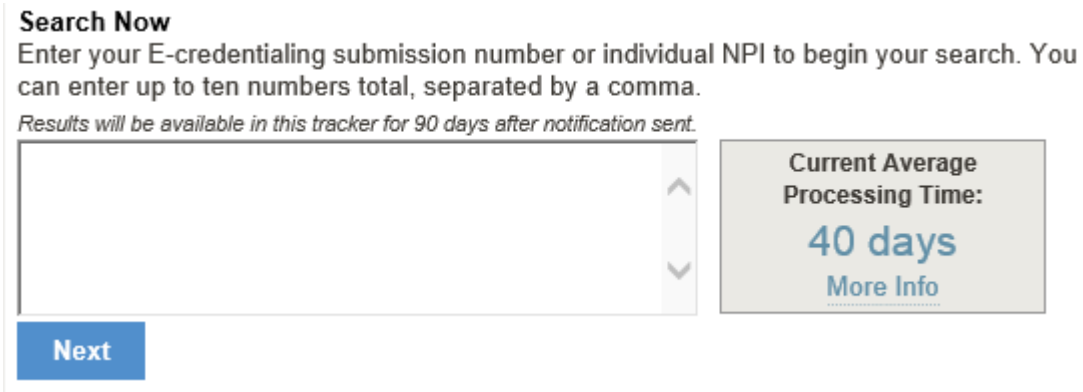
E-CRED CENTRAL

CURRENT TOOLS

- Change Request
  - Used to make various changes including, but not limited to:
    - Address update
    - TIN change
    - Name change
    - Backup provider change
- Provider Directory Validation
  - Used to validate the information for your organization
  - Every six months, Wellmark will send provider directory validation
- Short Application
  - The E-cred Application Tool gives practitioners the ability to add additional practice locations to the provider directory with ease
  - New practices can also use the application tool to register in the Provider Directory

AVERAGE PROCESSING TIME

- Current processing time for new applications is approximately 60 days
- Change request forms turn around is approximately 1-2 weeks
- All paperwork is being completed within the SD mandate language of 90 days
- The submission status tracker is a 12 month rolling average of all submissions



COUNTING DOWN TO A APPLICATION

Q4 of 2017 – New E-credentialing Central tool to launch

- The E-cred Application Tool full application will be available

ANNUAL PAYMENT UPDATE

PAYMENT UPDATE

- Annual payment update notice accessible on the Wellmark Provider Portal
- July 1, 2017 professional fee schedule update accessible on the Wellmark Provider Portal

ANNUAL PAYMENT -REMINDERS

- When comparing payment rates on claims with published fee schedules, please ensure that you have:

  The correct year selected

  The correct specialty

  The correct fee schedule i.e. HMO/PPO

- Many inquiries occur due to an incorrect fee schedule being referenced

UTILIZATION MANAGEMENT

UTILIZATION MANAGEMENT TOOL

To most effectively use the UM tool, remember too

- Have all clinical information
- Ensure the clinical information is entered correctly to avoid backtracking
- Submit all pertinent codes
- If the request does not meet medical necessity, be sure to include additional clinical information in the notes section
- Do not schedule non-emergent procedures prior to receiving approval
- Have the Smart Sheets available to become familiar with the medical necessity criteria

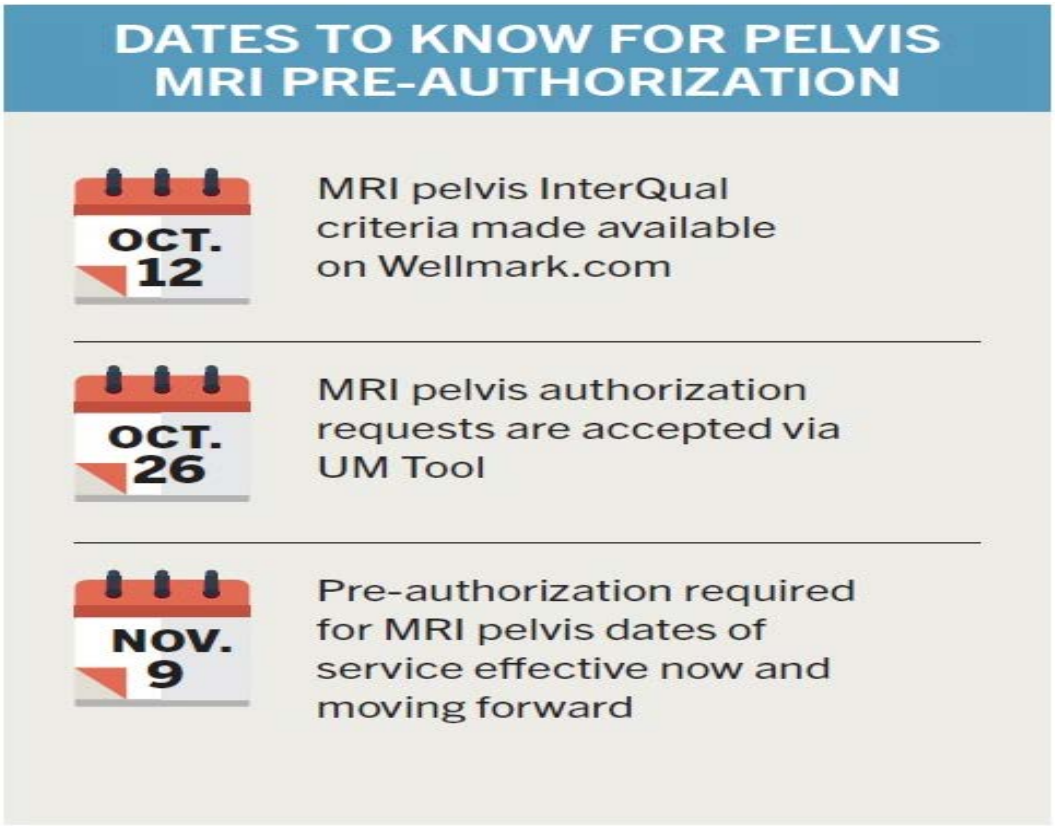
PRIOR AUTHORIZATION UPDATES

Procedures no longer needing prior review for dates of service June 22, 2017 and after:

Service	CPT/HCPCS Code
Stress Echo	93350, 93351
CT Colonography	72461, 72462, 72463
MRI Breast	77058, 77059
CTA Coronary Artery	75574
PET Brain	78608, 78609
Capsule Endoscopy	0355T, 91110, 91111
Surgical Management of Obstructive Sleep Apnea	21198, 21199, 42145

MRI PELVIS

MRI Pelvis is being added to the list of imaging services that require prior authorization



WORKING WITH WELLMARK

TIME SAVING IMPROVEMENT FOR CLAIMS FILING

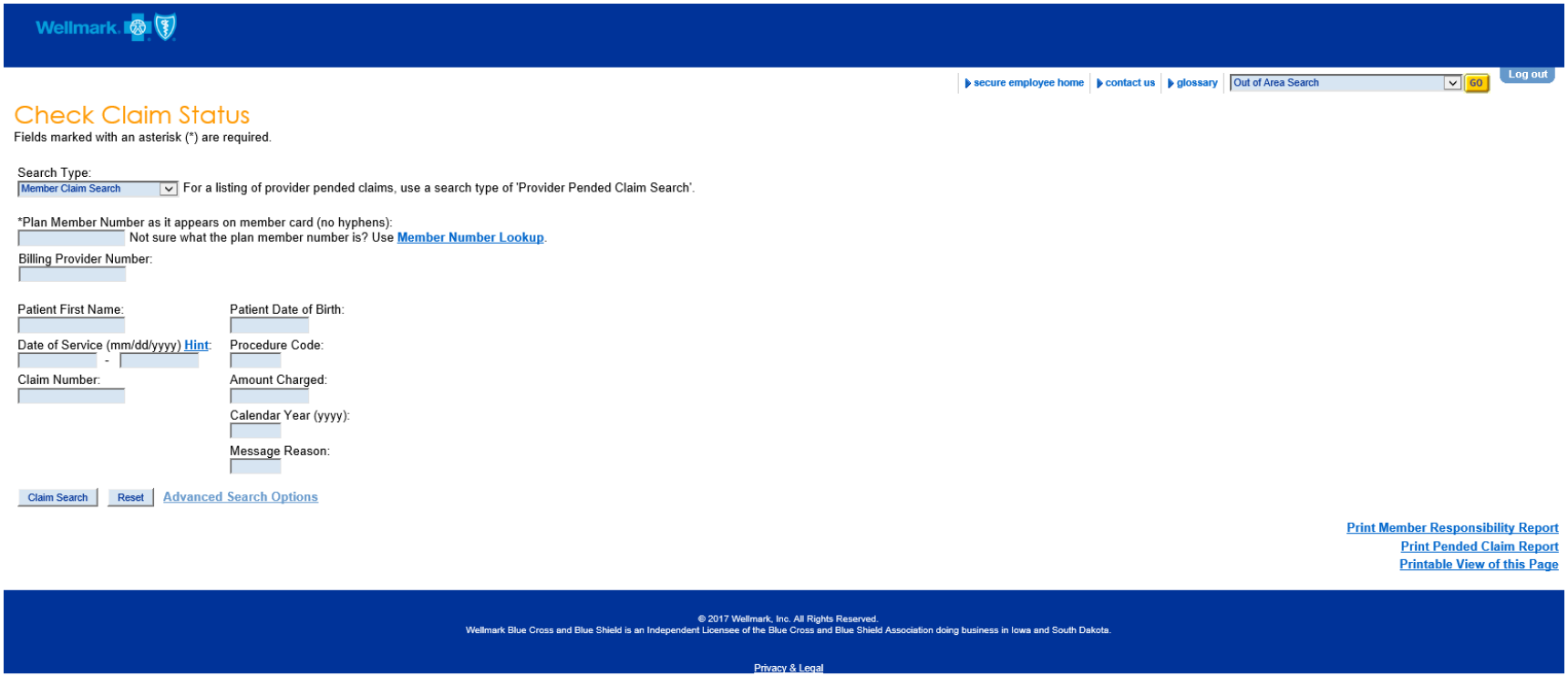
Prior to August 1, 2017, if a claim with an unlisted/not otherwise classified (NOC) procedure code was denied due to not meeting criteria, providers were asked to include a medical record/report of the services when resubmitting the claim

Effective August 1, 2017, providers will only see the X922 denial code when an unlisted/NOC procedure code is submitted without the description

Providers can resubmit the claim electronically because the medical record or report is not needed

Please refer to the Claims Filing Section of the Provider Guide- Chapter 17 for additional direction

NEW OUT OF AREA SEARCH PAGE FOR PROVIDERS



SUBMITTING CORRECTIONS FOR FACILITY CLAIMS

- Wellmark prefers all charges for a DOS to be submitted on a single claim
- Corrections for inpatient and outpatient services should be completed after the original claim has finalized and generated a PCR
- Use the appropriate TOB to indicate changes are being made to the original claim
    - For example, TOB XX7 for the replacement of a prior claim
- Please refer to the Claims Filing Guide to determine when to void a claim versus filing an inquiry for a claim adjustment

MEDICAL RECORDS REQUESTS FOR AUDIT PURPOSES

- Medical records are requested for many purposes, including for auditing purposes
  - Requests from Wellmark or from other BCBS plans
- Pursuant to Wellmark's provider network participation agreement, providers must accommodate Wellmark's request for medical records
- Wellmark does not pay for requested medical records
- **If you work with a health information management vendor, please notify them of Wellmark's policy**

ACCEPTING MEDICAL RECORDS FOR CLAIM ISSUES

Effective May 1, 2017 Wellmark changed the process for medical record submissions and will only accept records via the following ways:

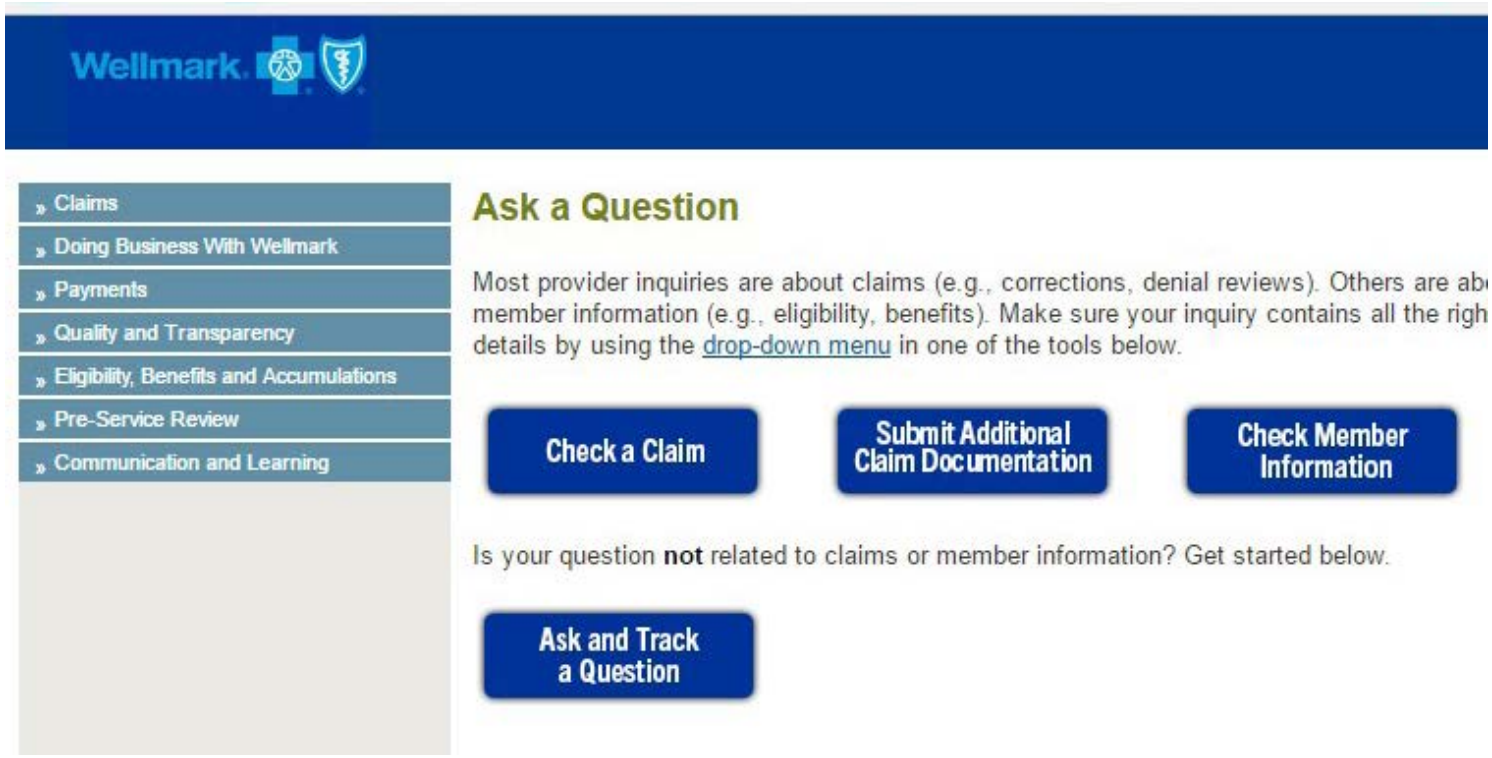
- Attached to a Provider Inquiry
- Attached to a paper Provider Inquiry form
- Attached to a medical records request letter sent by Wellmark

If not received by the above means, the records will not be retained.

ACCEPTING MEDICAL RECORDS FOR CLAIM ISSUES

To make the process easier, Wellmark added a button to the Ask and Track a Question tool.

- Submit Additional Claim Documentation



WELLMARK INFORMATION NOTIFICATION SYSTEM (WINS)

- Real time notification
- Messaging focuses on:
  - Wellmark policy changes that impact you and your business and/or business processes – such as medical policy updates
  - Issues that impact how Wellmark does business with the provider community
- How Do Providers Sign-up for WINS?
  - Log into Wellmark.com secure portal
  - Click on **Wellmark Information Notification System (WINS)** under **Quick Links**
  - Complete basic demographic information
  - Select message categories in which you are interested

71% Of providers surveyed indicated WINS is an effective communication method

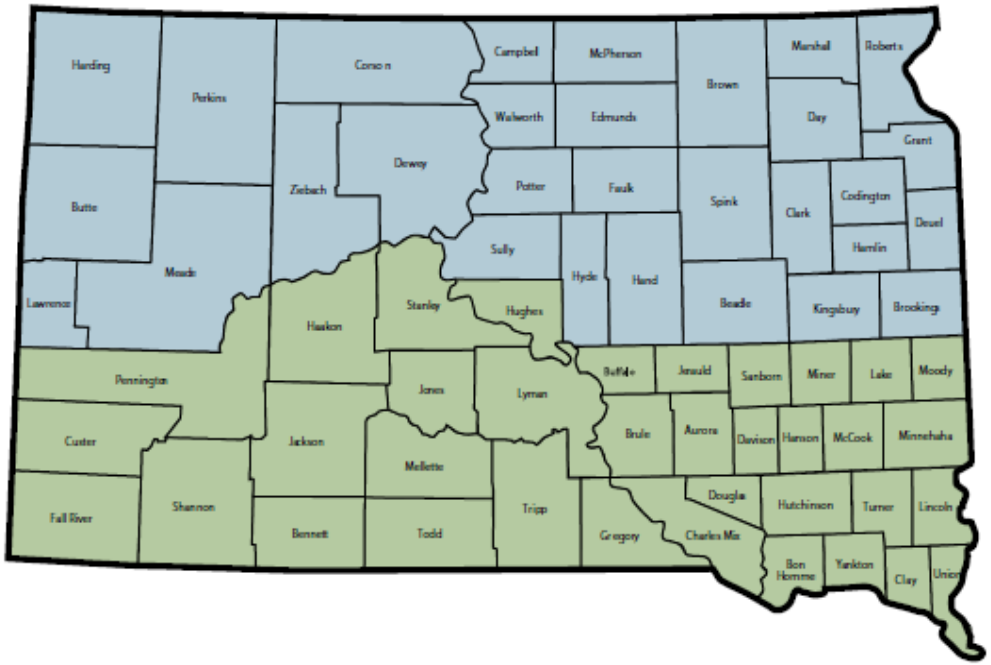
CONTACTS

SOUTH DAKOTA NETWORK ENGAGEMENT TERRITORY MAP

Wellmark. South Dakota

NETWORK ENGAGEMENT TERRITORIES

SOUTH DAKOTA



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South Dakota Provider Contact Information

- In-State Health Benefit or Claim Status Information
- Out-of-State (BlueCard®) Health Benefit or Claim Status Information
- Case Management Situation
- Claims
- Contracting & Credentialing
- Condition Support
- Network Engagement
- BlueInk
- Outpatient Diagnostic Imaging
- Pharmacy
- Web Self-Service Tools

To Contact Us About	Electronic Resources	Phone or Fax
In-State Health Benefit or Claim Status Information		
Classic Blue® & Blue Select®	Contact us Securely: Ask & Track a Question Secure Web Tools: • Check Claim Status • View Eligibility and Benefits • First-time Users	800-774-3892 605-373-7292 Fax: 515-376-9098 Monday-Friday, 9 a.m.–5 p.m. CT
Federal Employee Program (FEP)	Contact us Securely: Ask & Track a Question	888-800-1359 Fax: 515-376-9066 Monday-Friday, 9 a.m. to 5 p.m. CT

THANK YOU!

Kathy Johnson and Deb Wilcke