

Marketplace, BlueCard[®] and Kansas Provider Networks





Table of contents

- Marketplace background 2
- Health Insurance Marketplace 2
- Health plan accreditation..... 3
- BlueCard for public
Marketplace products 3
 - Blue Plan member ID cards 4
- Health identification card and logos 4
 - BlueCard suitcase logos 5
- Kansas provider networks
and contracts..... 6
 - Competitive Allowance Program (CAP)..... 6
 - Blue Choice..... 6
 - Exclusive Provider Network 6
 - Plan 65-Select 6
 - Value Blue 6
 - Provider directories 6
- 2023 Blue Cross and Blue Shield of Kansas
(BCBSKS) product offerings 8
 - BCBSKS member ID card prefixes..... 8
 - Preferred Care Blue on KS member ID cards 8
 - EPO differences from PPO 9
 - Provider network 9
 - 2022 EPO member ID card examples 10
- Claims filing and other procedures 11
 - Marketplace individual grace period 11
 - Referring provider required on claims
for Indian Health (Native American) Services 11
- Commercial risk adjustment 12
 - Risk adjustment data validation audit 12
 - Medical records requests..... 13
 - HIPAA/privacy 13

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.

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 Nov. 1, 2022 through Dec. 15, 2022. Plans purchased by December 15, 2022 will be effective Jan. 1, 2023.

The Marketplace is a website through which eligible consumers may purchase insurance. It is 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 promise is to enhance competition in the health insurance market, improve choice of affordable health insurance and give individuals purchasing power comparable to that of large businesses.

Health Insurance Marketplace

The Health Insurance Marketplace offers 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 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: bcbsks.com/individual-and-family-plans.

Health Plan Accreditation

Insurance companies selling products in the Marketplace must have achieved Health Plan Accreditation through an approved accrediting entity. 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.

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 Marketplace products

The Blue Cross and Blue Shield Association (Association) has worked closely with 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 identification (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> | <p>Preferred Care Blue (Kansas City’s network)</p> | <p>Individual SHOP</p> |
|  | <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> | <p>Blue Choice Preferred Care Blue (Kansas City’s network)</p> | <p>Individual Small Group</p> |
|  | <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> | <p>Limited benefit products</p> | <p>Individual Small Group SHOP</p> |
|  | <p>The “MA in a suitcase” logo on the front of the member’s ID card means the member has in-network coverage through the Kansas Preferred Blue Medicare Advantage Network.</p> | <p>Limited benefit products</p> | <p>Medicare Advantage</p> |
| <p>No logo</p> | <p>No logo means the member has in-network coverage and only emergency out-of-network coverage. These products can be purchased on or off the Marketplace.</p> | <p>Limited benefit products</p> | <p>EPO</p> |

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)

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

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.

Exclusive Provider Network

Exclusive Provider Network is the network that represents all providers enrolled in Blue Choice. EPO products have only in-network and emergency benefits.

Plan 65-Select

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.

Kansas Preferred Blue Medicare Advantage

Launched in 2020, Kansas Preferred Blue Medicare Advantage is the network for Blue MA, an authorized Medicare Advantage Organization that contracts with the Centers for Medicare and Medicaid Services (CMS) to offer Medicare Advantage and prescription drug insurance plans in the senior market.

Value Blue

Value Blue is a network of providers who have agreed to accept 50 % of the Blue Choice 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 provider directory on the BCBSKS website, mobile version or mobile app, or by providing the prefix when calling the BlueCard Access call center.



2023 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.

| Prefix | Network and product description |
|--------|------------------------------------------|
| XSB | Blue Choice Small Group off Marketplace |
| XST | Blue Choice Individual off Marketplace |
| XSN | EPO—Individual on Exchange |
| XSZ | EPO—Individual off Exchange |
| KSA | EPO—Small Group off SHOP |
| M3A | Kansas Preferred Blue Medicare Advantage |

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.

Prefix — identifies product and benefits

Copay and deductibles

The image shows two sample member ID cards. The left card is for 'BlueChoice Preferred-Care Blue' with member JOHN D SMITH and ID number XSB23456789. It lists various copays and deductibles. The right card is for 'BlueCross BlueShield of Kansas' with contact information and a pharmacy benefits administrator logo.

Dental benefits — if blank, no dental coverage

Suitcase logo — helps determine network and benefits

Prescription benefit — if blank, no prescription benefit

EPO differences from PPO

EPO products are different than PPO products in Kansas. PPO products cannot vary more than 30% of the actuarial value between in- and out-of-network benefits. EPO products are not limited to the 30% 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.).

Provider network

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



2022 EPO member ID card examples

The EPO Member ID card has no suitcase logo, which signifies the member has out-of-area coverage for emergency services or services not provided in network.

The EPO ID card for members health and dental benefits will the dental logo at the bottom of the card.

Prefix — identifies product and benefits

Copay and deductibles

Dental benefits — if blank, no dental coverage

Suitcase logo — helps determine network and benefits

Prescription benefit — if blank, no prescription benefit

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

The EPO card has no suitcase logo, which signifies a lack of out-of-network benefits.

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 Field Locator (FL) 78 of the UB-04 claim form. The electronic equivalent to FL 78 is 2310F (claim level) or 2420D (line level).



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 with BCBSKS' Risk Adjustment Outreach staff retrieving the medical records and the Initial Validation Auditor (Change Healthcare) completing the required risk adjustment coding audit of claims and medical records.

Medical records requests

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

Specific to the ACA's Commercial Risk Adjustment process and for the U.S. Department of Health and Human Services Risk Adjustment Data Validation Audit, BCBSKS conducts medical record requests. Requests for member records will be received directly from BCBSKS' Risk Adjustment Outreach Staff.

As outlined within the provider contract, all pertinent and complete medical records must be provided or made available by the contracting provider. Following are the methods records may be submitted:

- Email to: risk.adjustment@bcbsks.com
- Secure fax to **785-290-0708**
- By mail to:
Blue Cross and Blue Shield of Kansas, cc851B3
PO Box 239
Topeka, KS 66601
- Or by mail service (FedEx, UPS, etc.) to:
Blue Cross and Blue Shield of Kansas, cc851B3
1133 SW Topeka Blvd.
Topeka, KS 66629
- For minimal disruption, BCBSKS can coordinate remote access through the provider's EMR system. To elect this option, please contact: Jamie Schnacker CPC, CRC at jamie.schnacker@bcbsks.com or **785-291-6796**.

HIPAA/privacy

BCBSKS and third-party vendors requesting medical records are 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 [hhs.gov/ocr/privacy](https://www.hhs.gov/ocr/privacy).



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