Provider Update

2016 Tennessee Medicare Advantage Plan Changes

Annual benefits changes for Medicare Advantage plan members will be effective January 1, 2016. Each year, we renew our contract with the Centers for Medicare and Medicaid Services (CMS) and CMS re-evaluates and approves the benefits we'll offer to our Medicare Advantage members for the upcoming year.

The below changes apply to our 2016 Medicare Advantage plans. You can help members manage their health care costs by being aware of these changes. .

Notable 2016 benefits changes and highlights:

- In 2016 our pan names are changing. This includes removing the "+Rx" from the end of each Amerivantage name. Please note: Although "+ Rx" will be removed from the plan name, these plans will continue to offer Part D Prescription Drug coverage.
- In 2016 our Amerivantage Specialty + RX (HMO SNP) is changing its name to Amerivantage Dual Coordination (HMO SNP).
- 2016 Plans may include changes to Medical and Part D benefits, copayments and/or coinsurance, deductibles, formulary coverage, pharmacy network, premium and out-of-pocket maximums. Please check the member's benefits for the new Plan year changes, by visiting our website at (Patrick put in web address) or calling provider services at https://www.myamerigroup.com/Medicare2016/Pages/Tennessee/Tennessee.aspx or calling provider services at 1-866-805-4589.
- If members receive two or more services from the same provider during the same visit and/or on the same day, members will be responsible to pay the copay for each applicable service.
- Our plans may use an independent network of providers for "routine" dental, hearing and vision care. If you have questions on whether you are eligible to be reimbursed for providing these services, please call provider services at1-866-805-4589.
- In 2016 members enrolled in our Medicare Advantage plans that provide routine hearing exam and/or hearing aid benefits will obtain services through Hearing Care Solutions.
- Insert if applicable: For our Medicare Advantage plans that provide supplemental transportation services, covered trips may be used for preventive and routine services
- Please check the member ID card for any identification and/or group number changes that may affect claim submissions.

New Plans and Service Area Changes:

- In 2016, we will be reducing the service area of the current Amerivantage Classic (HMO) in the following counties Anderson, Bedford, Bledsoe, Blount, Bradley, Carroll, Carter, Chester, Cocke, Coffee, Crockett, Cumberland, Franklin, Grainger, Grundy, Hancock, Hardeman, Hawkins, Haywood, Henderson, Humphreys, Johnson, Lauderdale, Loudon, Madison, Marion, Monroe, Moore, Morgan, Obion,

Picket, Rhea, Scott, Sequatchie, Smith, Sullivan, Trousdale, Unicoi, Union, Washington, Weakley The CMS Contract number and Plan Benefit package for this plan is H7200-07.

- In 2016, we will be expanding the existing Amerivantage Classic (HMO) into Claiborne and Jefferson counties. The CMS Contract and Plan Benefit Package for this plan is H7200-007.
- In 2016 we will be offering a new Amerivantage Classic (HMO) in the following counties: Anderson, Bedford, Bledsoe, Blount, Bradley, Campbell, Cocke, Coffee, Cumberland, Franklin, Grainger, Grundy, Hancock, Hawkins, Humphreys, Lauderdale, Loudon, Marion, Monroe, Moore, Morgan, Obion, Pickett, Rhea, Roane, Scott, Sequatchie, Sevier, Smith, Trousdale, Union, and Weakley. The CMS Contract number and Plan Benefit package for this plan is H7200-013.
- In 2016, the Amerivantage Dual Coordination (HMO SNP) service area is expanding to the following counties: Campbell, Claiborne, Hamblen, Jefferson, Lake, Roane, and Sevier. The CMS Contract and Plan Benefit Package for this plan is H7200-006.

Diabetic Supplies:

Effective January 1, 2016, all of our Medicare Advantage plans will only cover certain lancets if they are purchased at one of our network pharmacies or through our mail-order service. Lancets will be limited to the following manufacturers: Lifescan / Delica, Roche, Kroger and its affiliates which include Fred Meyer, King Soopers, City Market, Fry's Food Stores, Smith's Food and Drug Centers, Dillon Companies, Ralph, Quality Food Centers, Baker, Scott's, Owen, Payless, Gerbes, Jay-C, Prodigy, and Good Neighbor.

Up to 100 lancets per month will be covered.

Members impacted by this change will be notified in October through their Annual Notice of Change and Evidence of Coverage plan benefit materials.

To be covered at a $0 copay, the members must purchase these supplies at an in-network retail or mail-order pharmacy supplier.

As a reminder, providers that participate in a delegated arrangement with the health plan are responsible for the provision of services as indicated in the Division of Financial Responsibility (DOFR) section of the provider group's contract or services agreement. If your provider group participates in a delegated arrangement, please remember that diabetic test strips and Part B drugs must be supplied at the provider's office and not through a retail pharmacy or mail-order service.

New Year! New Formulary Changes!

Provider Update

Each year we evaluate our benefits and formulary and may make changes to update them. Formulary changes in the upcoming year include: tier changes, drug removals, and new Prior Authorization and Quantity Limit requirements.

Your patients will have formulary changes and will need your help to ensure they get their needed treatments at the most affordable cost.

Please, encourage your patients to review the 2016 formulary information within their Annual Notice of Change (ANOC) mailing or their new member kit, or to view the information online when it is available, beginning October 1. Ask them if the coverage for any of their prescriptions has been changed, and consider alternative medications in a lower cost-sharing tier that may meet their needs.

Pharmacy Benefit Changes for 2016:

Our MAPD plans have a pharmacy network that includes preferred and standard network retail pharmacies. Member's save more by paying a lower cost-sharing amount at preferred cost-sharing pharmacies. Our preferred cost-sharing pharmacies include **CVS/pharmacy, Harris Teeter Pharmacy, Kroger, Target, Sam's Club, Walmart and some independent pharmacies within specific geographical areas.**

- CVS/pharmacy participating pharmacies include CVS/pharmacy, Longs Drug Stores and Navarro Discount Pharmacies.
- Kroger participating pharmacies include Kroger, Fred Meyer, King Soopers, City Market, Fry's Food Stores, Smith's Food & Drug Centers, Dillon Companies, Ralphs, Quality Food Centers, Baker, Scott's, Owen, Payless, Gerbes, and Jay-C.
- Walmart participating pharmacies include Walmart, Neighborhood Market and Sam's Club.

Members can fill a prescription at a network retail pharmacy, but their cost-sharing amount may be higher.

Enhanced Benefits:

Our MAPD plans have select care drugs at a $0 cost share for the following conditions: high blood pressure, high cholesterol and diabetes. The following drugs will be on the $0 cost share tier:

- ENALAPRIL MALEATE
- PRAVASTATIN SODIUM
- LOSARTAN POTASSIUM/HYDROCHLOROTHIAZIDE
- LISINOPRIL
- LOVASTATIN

- METFORMIN HCL
- BENAZEPRIL HCL
- ENALAPRIL MALEATE/HYDROCHLOROTHIAZIDE
- GLIPIZIDE
- GLIMEPIRIDE
- ATORVASTATIN CALCIUM
- SIMVASTATIN

Balance Billing Reminder:

The Centers for Medicare and Medicaid Services and our plan does not allow you to "balance bill" Medicare Advantage HMO and PPO members for Medicare covered services. CMS provides for an important protection for Medicare beneficiaries and our members such that, after our members have met any plan deductibles, they only have to pay the plan's cost-sharing amount for services covered by our plan. As a Medicare provider and/or a plan provider, you are not allowed to balance bill members for an amount greater than their cost share amount. This includes situations where we pay you less than the charges you bill for a service. This also includes charges that are in dispute.

Amerivantage Dual Coordination (HMO SNP):
To fulfill state and federal contractual requirements, this plan applies the Medicare statutory amounts to Medicare covered services. The remaining Medicare Advantage deductible, coinsurance or copayment amounts are then applied to the members' Medicaid benefits; those claims are processed subject to Medicaid processing guidelines.

Under Medicaid, additional payment may be available dependent upon the Medicaid rate of reimbursement. If the Medicaid rate of reimbursement is more than the filed Medicare benefit, the difference will be paid to the provider. If the Medicaid rate is less than what the filed Medicare benefit has already paid on that claim, no additional payment will be made. Providers are prohibited from balance billing members for any portion of that Medicare cost share that is deemed not covered under their Medicaid benefit.

Annual Wellness Visit:

All Medicare Advantage plans cover the AWV. Members are encouraged to use this annual benefit as one way to help assess current health status and future needs.

What Does the Annual Wellness Visit Cover?

All of our Medicare Advantage plans cover the AWV. Members are encouraged to use this annual benefit as one way to help assess current health status and future needs.

For the first visit, providers should bill G0438 for the AWV which includes the Personalized Prevention Plan Service. Thereafter, providers should bill G0439 for the AWV and Personalized Prevention Plan Service for subsequent visits.

What if Additional Services Are Provided at the Same Time As the AWV?

If other evaluation and management services are provided in conjunction with the AWV, use CPT Modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) as appropriate.

Prior Authorization Updates for Medicare Advantage Plans:
Providers are required to periodically review and comply with the latest Medicare Advantage Prior Authorization requirements found at https://providers.amerigroup.com/pages/pluto.aspx

Referral Process Updates for our Medicare Advantage Plans:
In most situations, our members may need to receive a referral from their PCP before they can use specialists in the Plan's network. Examples of specialists include Cardiologists, Dermatologists, Orthopedic surgeons, Oncologists and Urologists. However, referrals from a PCP are not required for emergency care or urgently needed care. There are also other kinds of care members can obtain without having approval in advance from their PCP.

Please visit our website at https://providers.amerigroup.com/pages/tn-2012.aspx for more detailed product information or contact Provider Services at the number on the back of the member's ID card. You can find important Medicare Advantage updates in the Plan & Administrative Changes/Update section. Contact your provider representative for participation details for our contracted plans.

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Amerivantage is a DSNP plan with a Medicare contract and a contract with the State Medicaid program. In New Mexico: Amerivantage is an HMO with a Medicare contract. Enrollment in Amerivantage depends on contract renewal.

*In New Mexico, Amerigroup Community Care of New Mexico, Inc. In Texas, Amerigroup members in the Medicaid Rural Service Area are served by Amerigroup Insurance Company; all other Amerigroup members are served by Amerigroup, Texas, Inc. In Washington, Amerigroup Washington, Inc.