We’re happy you’re here.

Provider Education

Presented by: Network Management Department

Martin’s Point

Overview

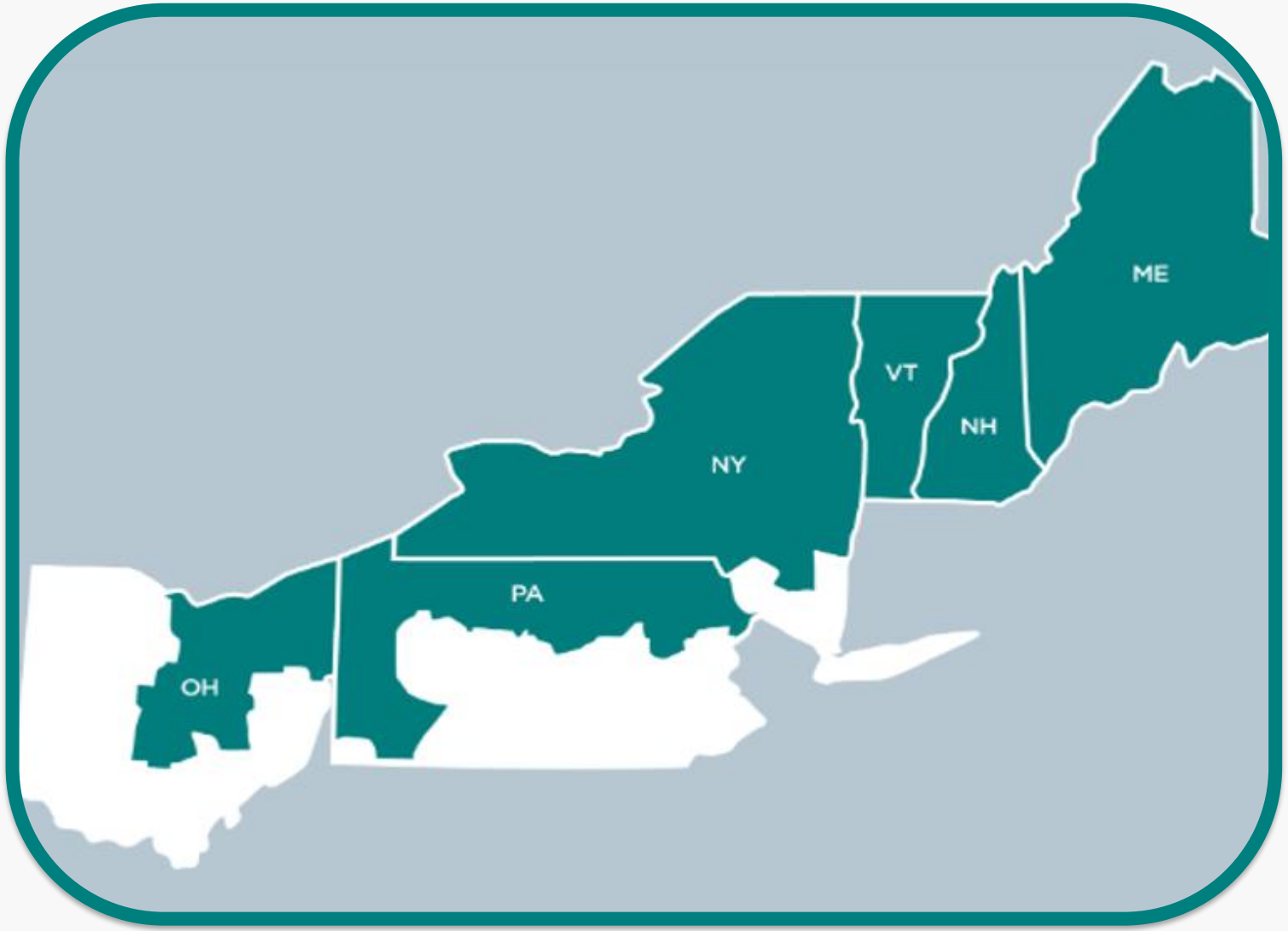
Martin's Point

Who We Are

- Headquartered in Portland, Maine
- Not-for-profit
- Physician-led
- Certified Great Place to Work® since 2016

Martin's Point

What we do…



- **US Family Health Plan**
  - **Maine**
  - **New Hampshire**
  - **Vermont**
  - **New York**
  - **Pennsylvania**
  - **Ohio**
- **Generations Advantage**
  - **Maine**
- **Health Centers**
  - **5 in Maine**
  - **1 in New Hampshire**

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Our Health Plans

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Our Health Plans

We offer two federally administered health plans:

Martin's Point US Family Health Plan

- Our TRICARE Prime® plan covers over 46,000 active-duty and retired military family members in Maine, New Hampshire, Vermont, upstate New York, northern and western Pennsylvania, and northeastern Ohio.

Martin's Point Generations Advantage

- Our Medicare Advantage plans cover seniors in Maine.
- These are Maine's most popular Medicare Advantage plans with over 66,000 members.

Quality Ratings

- Both of our health plans are highly rated for quality and customer service.

US Family Health Plan: Details & Benefits

Active-duty family members

Retirees, survivors, and family members

- Complete medical, hospital, and prescription drug coverage.
- Low or no copayments in-network.
- Low prescription drug copays.
- Out-of-network flexibility for certain services with Point of Service (POS) benefit.

The US Family Health Plan goes beyond traditional TRICARE® Prime benefits to offer excellent customer service and value-added benefits, including discounts on:

- **Eyewear**
- **Hearing aids**
- **Fitness memberships**
- **More**

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US Family Health Plan: Focused on Quality for Our Members

Voluntary Submission to NCQA Rating

- We submit our US Family Health Plan for a rigorous annual review by NCQA—national agency that accredits health plans.
- Compares quality and service of over 1,000 health plans on a scale of 0-5
- Assesses: Structure, Process, Performance, Customer Satisfaction
- US Family Health Plan Current Ratings thru 2026
  - 4 out of 5 rating for quality performance
  - 5 out of 5 for Patient Experience measures

US Family Health Plan: TRICARE® Prime Reminders

- If a Medicare or a “Medicare-type” waiver is used, Defense Health Agency (DHA) will not honor it. The best recommendation is to use the approved Martin’s Point Agreement to Financial Responsibility form.
- No deductibles or cost shares for preventive services in network.
- Annual physicals each year at no additional cost for the member.
- Many genetic lab tests requires prior authorization. Submit authorization in advance and, when possible, please direct member to providers in the Martin’s Point US Family Health Plan network.

US Family Health Plan: TRICARE® Prime Reminders - continued

Referrals:

- Specialty care with an in-network provider is covered at the TRICARE® Prime level and **does not** require plan approval.
- The referral should be sent directly to the specialist and a copy provided to the member. Submission through ProAuth™ is optional.
- All specialty care provided by **non-participating (out-of-network)** providers must have an **approved authorization** to process at the standard TRICARE® Prime benefit level.
- If a member chooses to receive care from a non-participating (out-of-network) provider, they may do so without prior approval, but the services will be processed under the POS benefit level, resulting in higher out-of-pocket costs.

Auth Requirements for UM Imaging:

- Authorization is required for PET, SPECT, Cardiac PET and SPECT.
- Please utilize the Pro Auth tool to submit authorization requests.

Generations Advantage: Details & Benefits

Medicare Advantage plan types

- HMO-POS, HMO, and LPPO
- Market locations: Maine

All Martin's Point Generations Advantage plans go beyond Original Medicare to include value-added benefits including:

- $0 in-network preventive screenings/care
- No medical/hospital deductibles
- $0 annual in-network physical exam and wellness visit
- Annual out-of-pocket maximum
- Worldwide urgent & emergency care
- Hearing aids and batteries
- Over-the-counter items
- Wellness Wallet
- Prepaid MasterCard for qualifying benefits
- $2,100 Part D Prescription out-of-pocket maximum

Generations Advantage: Focused on Quality for Our Members

- Medicare Star Ratings for Performance and Quality
  - Staying healthy: screenings, tests, and vaccines
  - Managing chronic conditions
  - Plan responsiveness and care
  - Member complaints, problems getting services, and choosing to leave the plan
  - Health plan customer service
- Star ratings: 1 (poor) to 5 (excellent)
- Martin's Point Generations Advantage 2026 Star Ratings:
  - 4-out-of-5 Stars for HMO/HMO-POS

Generation Advantage: Reminders

- If an ABN or an “ABN-type” waiver is used, the Centers for Medicare & Medicaid Services (CMS) prohibits Medicare Advantage plans from honoring it. Providers must follow Martin’s Point Agreement to Financial Responsibility policy.

- Not all vaccinations are eligible for coverage in the Part B setting. Providers should direct members to the pharmacy for Part D vaccinations.

- Please direct members to providers who are in the member’s plan network. If that’s not possible and you must refer a member out of network, you must submit an authorization request through ProAuth on our Provider Portal in advance. Our Health Management Department can answer any questions regarding an authorization request at 1-888-339-7982.

Provider Guidance – Clear and Legible Reports (CLR)

A clear and legible report, also known as a patient encounter form, should be sent to the referring provider when treating a Martin's Point US Family Health Plan or Generations Advantage member.

- **Urgent/emergent situations**
  - A preliminary report of a specialty consultation must be sent to the beneficiary's primary care manager (PCM) within 24 hours via telephone, fax, or another method. A formal written report must be submitted within 7 days of the encounter.

- **General submissions**
  - Consultation or referral reports, operative reports, and discharge summaries should be sent to the PCM within 7 calendar days of the encounter date. Reports must be submitted within 30 calendar days.

All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service, as outlined in 482.24(c)(1).

Network Management Department Overview

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Network Management Department

Provider Relations

- Manages provider contracts
- Builds and maintains provider networks
- Provides education and orientation to support the delivery of high-quality care
- Collaborates with our health plan and community partners on monitoring performance to support quality initiatives and regulatory compliance

Provider Data Integrity

- Processes provider changes/updates
- Maintains provider data; including online provider directory

Provider Credentialing

- Assesses qualifications, relevant training, licensure, certification and/or registration to practice for each health care professional who participates in our health plan networks

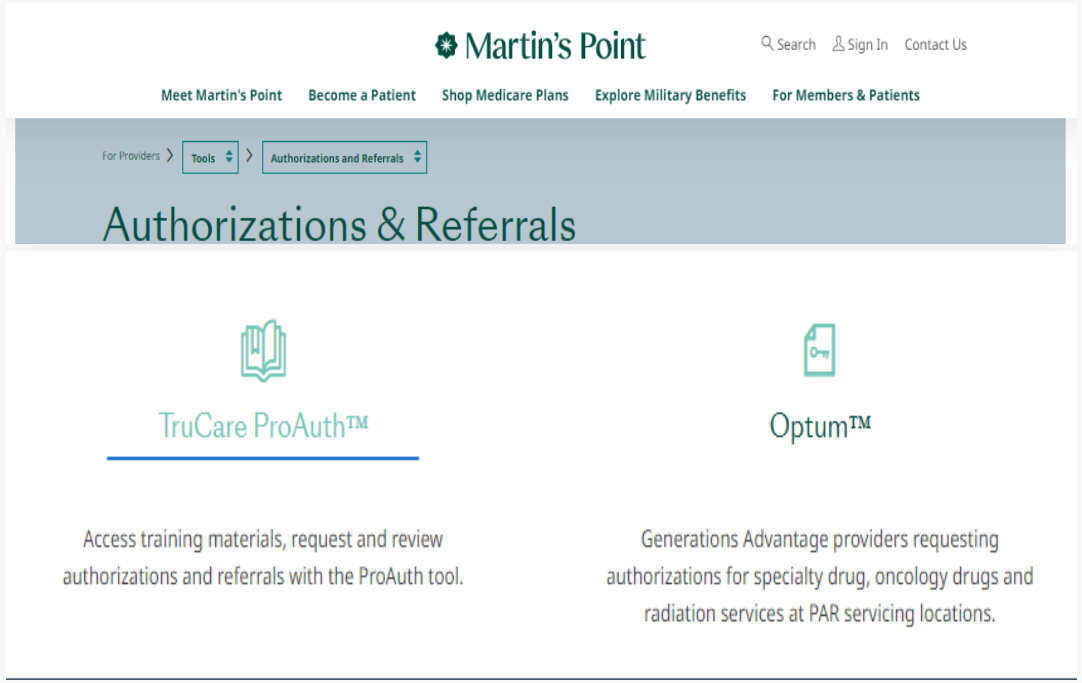
Health Management Department Overview

Martin's Point

Health Management Department—Roles & Functions

	Functions	Roles
Utilization Management	• Authorizations • Medical necessity reviews • Referrals	RNs & MDs • Clinical review to determine medical necessity of requested services.
Care Management	• Transitions of care • Chronic and complex care • Behavioral health • ECHO/ABA • Maternity	RNs & LCSWs • Care coordination & management
Appeals	• Provider appeal rights	Appeal specialists & MDs • Processing of appeals
Quality & Analytics	• Reporting & clinical audits	Analyst & RN • Operational & regulatory reporting & auditing

TruCare ProAuth Electronic Authorization Tool



Benefits for providers:

- Reduces need to request additional information
- Real-time authorization/referral submission, status tracking, and auto-authorization/referral responses
- One-and-done authorization/referral submissions

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TruCare ProAuth Electronic Authorization Tool

Features of ProAuth:

- Pre-screen
  - Advanced capabilities for immediate response on the following:
    - Participant eligibility
    - Authorization/referral required
    - Duplicate authorization alert

- Interactive guidance
  - Required information is identified for provider

- Authorization/Referral-specific structured notes and attachments
  - Attach appropriate notes and attachments

Authorization Reminders

- Prior authorization is not required for emergency care.
- Prior authorization requests should be submitted at least 14 calendar days prior to the date of service or facility admission.
- Mental health/substance abuse services are managed through Behavioral HealthCare Program (BHCP.)
- Specialty drugs, oncology drugs, and radiation services at participating servicing locations are managed through Optum.

Care Management Programs

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Care Management Programs—Both Health Plans

Transitions of Care

To decrease readmissions

Details:

- An unplanned admission for medical and psychiatric stays
- Post-discharge outreach
- Followed for short term—30 days
- May include home visits for members who are at high risk for readmission

Chronic Care

To improve the health of the member by closing gaps in care, reduce exacerbation of their disease process and rehospitalization

Details:

- Identified with chronic disease and are high risk
- Enrolled for up to 180 days

Behavioral Health

To prevent and reduce hospital admissions and maximize access to integrated behavioral and medical services

Details:

- Severe and persistent mental illness or substance abuse diagnoses
- Enrolled for up to 180 days

Care Management Programs—US Family Health Plan

Extended Care Health Option (Echo)

Supplements the basic TRICARE program by providing financial assistance for an integrated set of services and supplies.

Details:

- Requires qualifying mental or physical disability
- Offers integrated services and supplies beyond those offered by the basic benefit

Maternity

To support perinatal health

Details:

- Support and guidance for expectant mothers
- Encourage enrollment of babies after birth
- Diaper incentive to participate

Provider Inquiry

Martin's Point

Claims Submission

- We offer two EDI options:
  - Office Ally Payor ID: MPHC1
  - Relay Health Payor ID: MPHC2

- Claims submitted without a physical address of where services were rendered will be rejected.

Provider Inquiry: Benefits, Eligibility, & Claims

- Guides providers on claim payments, retractions, and denials
- Educates providers on submitting claims, authorizations issues, disputes status, and appeals process
- Assists providers with benefit & eligibility questions
- Ensures our network providers and facilities meet or exceed standards of care established by NCQA and CMS to maintain a high-quality network for patients and members

Claims Review Process

- Claims Review Process
  - For questions that cannot be self-served through the portal, please contact our Provider Inquiry department.
  - If PI rep is unable to answer your question, they may offer to research and call back within 30 calendar days.
  - If Provider disagrees with dispute determination, they may request a second level dispute.

- The Claims Dispute Form must be submitted for disputes related to:
  - Code Review
  - Contract Terms
  - Coordination of Benefits
  - Duplicate Claim

- Providers can self-serve for remits/claims and benefits/eligibility
  - Provider Portal
  - External Benefit Repository

Retrospective Authorization Requests

U.S. Family Health Plan

- We will review retrospective authorization requests for all qualified care, before or after claim submission.
- Providers who submit after claim submission must do so within 120 days from date of denial.
- Providers may submit a retrospective authorization request on our provider website. Determinations are made within 30 calendar days of receipt of request.

Generations Advantage

- We will not accept any retrospective authorization requests. If the service meets one of the three exception criteria for retrospective review, then the provider must submit this request with an authorization dispute form.
- Participating providers must file a claim for the authorization denial and then will have 120 days from that remit date of denial to submit a request on our provider website with supporting documents that meet the exception criteria.

Member Liability: Non-Covered Services

US Family Health Plan

- The beneficiary must have been informed in advance that the services are excluded/excludable, and agree in advance in writing to pay for the services
- We recommend using the approved Martin's Point Agreement to Financial Responsibility form.

Generations Advantage

- The plan issued an Integrated Denial Notice (IDN) for services that may not be covered.
- The beneficiary was informed services were excluded as indicated in the "exclusions" section of the EOC. If they agreed in advance to pay for the services, then this must be documented in the patient record and must be in compliance with the Martin's Point Generations Advantage Acknowledgement and Financial Responsibility Policy available on the provider website.

Provider Online Tools & Resources

Martin's Point

Online Tools & Resources

MartinsPoint.org/For-Providers

On our website you can:

- View our provider manual
- Get clinical documentation resources
- Get pharmacy information
- Submit/check status of prior authorizations
- Submit/check status of credentialling applications
- Check claims status and details
- Check real-time benefits and eligibility
- Change your provider/practice contact information
- Log in to our Provider Portal

Provider Portal Functions

- Eligibility tool and how to search
- Member management tool and how to search
- Claims tool and how to search
- Remittance advice tool and how to search
- Authorization status tool and how to search
- Updates
- Martin’s Point contact information

Onboarding & Additional Education, Contacting Us

Martin's Point

Onboarding & Additional Education

- Participating providers are given initial onboarding and ongoing education to support delivery of high-quality care to Martin's Point members.
  - To attend our standing Monthly New Provider Orientation Webinar, please contact Network.Management@MartinsPoint.org.
- We've created an extensive training for our participating providers that we can deliver in a variety of ways:
  - In-person visit
  - Virtual/Conference call
  - Webinars
  - Email
- Additional education and training modules are available on our website
  - martinspoint.org/for-providers
- Our Provider Manual includes a guide to provider procedures

Contact Us

- **Provider Relations**: Education, Contracts
  - Email: Network.Management@MartinsPoint.org

- **Provider Inquiry Department**: Eligibility, Benefits, Claims, General Information
  - Phone: 1-888-732-7364
  - IVR: Option # 1 (self service for benefits, eligibility, and claims)

- **Health Management Department**: Preauthorization, Discharge Planning, Medical-Necessity Reviews, Subacute, Home Care, Transplant Services
  - Phone: 1-888-732-7364
  - Fax: 207-828-7865

- **Provider Data Integrity**: Provider Data Change Request
  - Email: Providerchanges@MartinsPoint.org