## Premier Health Group Update

We are resending the February edition of the Provider Brief to expand on clarification of the last day to submit claims article, found under the Network Operations section.

I would like to welcome you to our February edition of the Provider Brief. We value the opportunity to share news, update you regarding ongoing initiatives, and provide the information you need to help you better serve patients and the community.

This month you will learn about CMS' Merit-based Incentive Payment System, as well as the variety of annual well-visit options available for patients. In addition, we summarize our key access points for patients, and conclude with a report on the success of Premier Health's participation in CMS' Next Generation Accountable Care Organization.

Please feel free to contact us directly at (937) 499-7441 if you have any questions.

I look forward to working with you!

Yours in health,

Renee George

### IN THIS ISSUE



## Network Operations

### Directory Updates

A person who enrolls in a health insurance plan relies on provider directories to access in-network providers for their care. When the information is incorrect, it can create a barrier to members getting the healthcare they need.

Premier Health Plan's provider directories, utilized by Premier Health Employee Plan members, should be updated every 30 calendar days for continued accuracy. Practices must provide accurate office location, phone number(s) and hours of operation data to Premier Health Group (PHG). It's important to notify us when this information changes. Please communicate all provider changes (i.e. new providers, terminations, office changes, accepting new patients/not accepting new patients, etc.) to the PHG team using the Provider/Change of Address/Deletion Form.

This form is a fillable PDF file, which means you can type the needed information directly into the form on our website. Please email the completed form to **PHG@PremierHealth.com or fax to (937) 641-7377**.

### Medical Pay Policies

View the most recent commercial policies and procedures.

## Last Day to Submit Medicare and Commercial Group Plan Claims

This does not impact the Premier Health Employee plan. Please continue to submit claims for Premier Health Employee plan members following the normal process.

The last day to submit Medicare claims for Premier Health Plan Medicare Advantage members is March 31, 2019. CMS regulations allow claim submission for 365 days after the date of service.

The last day to submit Commercial Group plan member claims is June 30, 2019 which is 180 days after the date of service. Please allow 30 days for processing of all claims.

## Touch Points for Care

Premier Health Group is committed to helping patients choose the right care, at the right time, and in the right setting. There are several key access points that allow us to connect with patients.

- **Urgent Care:** Premier Health Urgent Care's welcome patients daily, 7 days a week, for treatment of minor health problems that can't wait until they can visit with their primary care doctor. Our Urgent Care Centers are fully equipped with lab and X-ray services to help accurately diagnose and treat patients. We welcome all ages. Urgent Care Centers are in Englewood, Vandalia, Huber Heights, Troy, Miamisburg, Springboro, Centerville and Mason. For scheduling, wait time, hours and insurance information visit http://www.PremierUrgentCareOH.com.
- **Emergency:** Premier Health's full-service emergency care and board-certified specialists are available for patients 24 hours a day, seven days a week, supported by CareFlight Air and Mobile Services. Emergency Centers are in Centerville, Englewood Dayton, Jamestown, Miamisburg, Middletown and Troy. Patients can view wait times at http://www.PremierHealth.com/ER.
- **Virtual Care:** For a flat fee Premier Virtual Care connects patients with a board-certified provider through video chat. These providers can help patients manage minor health issues that do not require a hands-on exam or test. To learn more visit http://www.PremierVirtualCare.com.

## Next Generation Accountable Care Organization

In 2017 Premier Health was selected by the Center for Medicare and Medicaid Services (CMS) to participate in the Next Generation Accountable Care Organization (NGACO). The organization was one of only 42 participating in NGACO that year and was only one of two without prior ACO experience.

The program essentially sought to test if strong financial incentives, improved tools for better patient engagement, and engaged care management would improve health outcomes and lower expenditures for Medicare fee-for-service (FFS) beneficiaries.

Altogether, Premier Health's ACO included 21,000 aligned beneficiaries over nine counties, along with over 120 Primary Care Providers. Care teams were provided with tools to help them better manage the beneficiary's care through developing communication and care coordination across the continuum.

Through these collaborative efforts, Premier was able to successfully generate a shared savings of $3.9 million for calendar year 2017, and the overall CMS program was able to generate savings of $208 million across all participating ACOs.

## Annual Preventative Visits

Annual Preventative Health Visits are a helpful tool for providers to help patients maintain their overall health and well-being. Most insurance plans and Medicare cover annual preventative visits, often at no cost to the patient and are available at nearly every stage of life.

- **Well Child Visits** are intended for patients from birth to 18 years of age and are intended to check growth and development, test vision and hearing starting at age 4, and provide timely vaccinations.
- **Annual Preventative Physical: Men and Women, 18-65** includes a full physical exam as well the development of a screening plan to help determine a screening plan for the next five to 10 years for blood pressure, cholesterol, breast cancer, sexually transmitted infections, diabetes, depression, addiction, and more. Providers may also use this opportunity to update immunizations and recommend counseling for concerns such as diet, obesity, sexually transmitted infection risk, tobacco use, alcohol misuse, and more.
  **Well-Woman Visits: Ages 18-64** includes an annual physical and a conversation about a patient's family and personal health history, and health concerns to help identify and prevent serious health issues. Providers will also develop a screening plan, update immunizations, and recommend counseling if needed.
- **Welcome to Medicare: Men and Women Turning 65:** Medicare will cover a free Welcome to Medicare Visit, at no cost within the first 12 months for patients who have Medicare Part B. This visit enables providers to review a patient's health history, health concerns, and review your medications and immunizations. Although this visit is not a physical, certain measurements will be taken, such as height, weight, blood pressure, and body mass index. The visit also includes a simple vision test, and a review of patient's safety and to determine if there are health issues that could become a concern in the future.
- **Annual Wellness Visit: Men and Women, 65 and Older:** Though not an actual physical, patients who have had Medicare Part B for longer than 12 months qualify for this visit to speak with a health care provider about health history and health concerns. Providers will review patient medications and immunizations, and they will complete a "Health Risk Assessment" questionnaire to help determine if any health issues could become a concern in the future.

**We ask that you remind your patients to schedule their annual preventative visit.**

## MIPS

The Merit-based Incentive Payment System, or MIPS, is a quality payment program designed by CMS for eligible clinicians who meet or exceed low volume thresholds. To be 2019 MIPS eligible, a clinician must:

1. Identify on Medicare Part B claims as a MIPS eligible clinician type
2. Have enrolled in Medicare before 2019
3. Not be a Qualifying Alternative Payment Model Participant (QP)
4. Exceed the Performance Year 2019 low-volume threshold
    - As an individual when reporting individually, or
    - At the group level by being in a practice that exceeds the low-volume threshold when reporting as a group or virtual group, or
    - As a MIPS APM participant that exceeds the low-volume threshold at the entity level

It is used to tie payments to quality and cost-efficient care, drive improvement in care processes and health outcomes, increase the use of healthcare information, and reduce the cost of care.

MIPS is based on allowed charges for covered professional services under the Medicare Physician Fee Schedule (PFS) and the number of Medicare Part B patients who are furnished covered professional services under the Medicare Physician Fee Schedule. Performance is measured through the data clinicians report in four areas - Quality, Improvement Activities, Promoting Interoperability (formerly Advancing Care Information), and Cost.

The MIPS Performance Year begins on January 1 and ends on December 31 each year. Program participants must report data collected during one calendar year by March 31 of the following calendar year. To learn more about the program and to check your participation status, please visit https://qpp.cms.gov/login.

## Direct Address for Members of PHG

One of ways that providers improve efficiency and communication (and meet requirements for the CMS MIPS program) is to electronically send referrals or summaries of care to other providers. This electronic communication between electronic medical record systems (EMRs) is done by sending the summary of care (aka CCD) to the next provider's Direct Address.

As more and more providers utilize this method of communication, we have collected direct addresses for many members of PHG. The spreadsheet contains the known direct addresses for PHG members. On the spreadsheet you will find two tabs – one for individual providers and one for group addresses.

**We ask that you please review the spreadsheet to determine if your address is listed. If you have a direct address for referrals and summaries of care but your address is not listed, please send it to us and we will include it in our next update. Send your updates or new addresses to: PHG@PremierHealth.com.**

## Compliance Questions?

If you have compliance-related questions or concerns, you are encouraged to report them! If your issues or concerns were not or cannot be addressed through normal channels (i.e., Provider Services or Provider Relations), you are encouraged to contact Compliance anonymously by using the Compliance Hotline at **(888) 271-2688**, available 24 hours a day, 7 days a week.

Please see the Premier Health Code of Conduct at: http://www.premierhealthplan.org/About-Us/ for additional information about on our non-retaliation policy and about reporting compliance questions or concerns confidentially and in good faith.

## Fraud, Waste and Abuse

Premier Health Plan is committed to building healthier communities in southwest Ohio. In one of our efforts to keep healthcare affordable, we seek to detect, correct and prevent fraud, waste and abuse. If you suspect fraud, waste or abuse please contact us at our toll-free number, **(855) 222-1046**.