PriorityHealth

Physician and practice news digest

Fall 2016

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National Drug Codes (NDC) required on claims as of Oct. 1, 2016

Applies to all plans, all drugs

As of Oct. 1, Priority Health will require the inclusion of National Drug Codes (NDC) on claims for services that include drugs. This aligns Priority Health billing requirements with many national payers.

Claims submitted with dates of service on or after Oct. 1, 2016 without NDC will be rejected. This applies to all Priority Health plans and applies to all drugs on the claim (even if the drug is not a covered benefit).

More information

We will continue to update our website to reflect this change and will share information and reminders as Oct. 1 approaches. Learn about including the NDC on claims in our Provider Manual or by searching NDC at *priorityhealth.com*.

Billing and payment

NDC numbers required for FFS Medicaid claims

(05-03-2016) A reminder that, under Medicaid billing rules, many fee-for-service claims require that you include the NDC number. Priority Health rejects qualifying claims that are missing an NDC number.

Drug test codes G0477-G0483 denied in error since Jan. 1, 2016

(07-26-2016) Since Jan. 1, 2016, Optum 360™ software has been denying claims for drug test codes G0477-G0483 in error. The Optum fix on August 2 corrected the problem with facility claims. Therefore, this issue has been resolved.

All first quarter facility claims that denied in error will be reprocessed, which can take approximately 45 days once the Optum system issue is corrected. Facility claims from April forward are marked for reprocessing.

In addition, professional claims are also being reprocessed, which can take approximately 45 days.

Provider-based billing change for Medicare Advantage members

(07-22-2016) For provider offices that participate in provider-based billing, please note that as of June 1, 2016, Priority Health Medicare has changed our process and our Medicare Advantage members are no longer responsible for the facility fee associated with your billing.

Members should not be asked to pay the fee at the time of service; simply submit billing to Priority Health for payment.

Reminder: Advance Beneficiary Notices banned under Medicare Advantage rules

(07-14-2016) Provider organizations should be aware that since May 2014 an Advanced Beneficiary Notice of Non-Coverage (ABN) is not a valid form of denial notification for Medicare Advantage plan members. ABNs, sometimes referred to as “waivers,” are used in the original Medicare program. However, you can’t use them for patients enrolled in Priority Health Medicare plans as CMS prohibits use of ABNs or ABN-like forms.

Providers must understand what services are covered

As a provider who has elected to participate in the Medicare program, you need to understand which services are covered by original Medicare and which are not. Priority Health Medicare plans are required to cover everything that original Medicare covers, and in some instances may provide coverage that is more generous or otherwise goes beyond what is covered under original Medicare.

As a Priority Health Medicare contracted provider, you are also expected to understand what is covered under Priority Health Medicare.

Pre-service organization determinations are provided by Priority Health

CMS mandates that providers who are contracted with a Medicare Advantage plan, such as Priority Health, are not permitted to hold a Medicare Advantage member financially responsible for payment of a service not covered under the member’s Medicare Advantage plan. The exception being: unless that member has received a pre-service organization determination (PSOD) notice of denial from Priority Health before such services are rendered.

PSODs can be initiated by you as the provider or by the member in order to determine if the requested/ordered service is covered prior to a member receiving it, or prior to scheduling a service such as a lab test, diagnostic test or procedure.

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If the member does not have a PSOD notice of denial from Priority Health on file, you must hold the member harmless for the non-covered services and cannot charge the member any amount beyond the normal cost-sharing amounts (i.e., copayments, coinsurance and/or deductibles).

PSODs are not needed for EOC exclusions and other clearly excluded services

Where a service is never covered under original Medicare or is listed as a clear exclusion in the member's Evidence of Coverage (EOC) or other similar plan document, a pre-service organization determination is not required in order for you to hold the member financially liable for such non-covered services.

Please note, services or supplies that are not medically necessary or are otherwise determined to be not covered based on clinical criteria do not constitute "clear exclusions" under the member's plan. The member is not likely to know from the EOC that such services will not be covered.

Holding members responsible

Reminder: unless a service or supply is never covered under original Medicare, you will only be able to hold a Priority Health Medicare member financially responsible if the member has received a PSOD denial from Priority Health and decides to proceed with the service knowing they will be financially liable.

Learn more about Medicare non-coverage and the pre-service organization determination process in the Provider Manual.

Claims submitted through Emdeon on 7/6/2016 denied as duplicates

(07-11-2016) On July 6, an EDI error caused Emdeon claims to be loaded and run multiple times, resulting in 35,000 claims from 472 providers to be denied as duplicates.

Claims do not need to be resubmitted: The original claims submitted will still process as usual for payment but you may see additional denials for duplicates.

Medicare DME vendor change effective 07/01/2016

(07-08-2016) Effective July 1, the Medicare Administrative Contractor (MAC) for our region has changed vendors for durable medical equipment (DME) claims processing and medical policy development from NGS CoreSource to CGS. All DME providers should have received advanced notice of this change from CMS in March.

Additionally, when making pre-service decisions about DME coverage, our medical team will now use the CGS local coverage determinations (LCD). Find new LCDs at *cgsmedicare.com*.

Therapy modifiers required to bill a physician, 1500 claim

(07-06-2016) As of Sept. 1, 2016, providers and clinics billing for therapy services on a 1500 claim form must use required corresponding therapy modifiers to ensure proper reimbursement. Therapy modifiers are required for all plans and products.

If you omit the therapy modifiers, you will only be reimbursed for one type of therapy regardless if physical therapy (PT), occupational therapy (OT) and speech therapy (ST) were all completed on the same day, instead of the allowed reimbursement for each therapy when modifiers are present.

Code modifiers indicate the type of therapy performed

Therapy pays per day, per type of therapy. Since PT, OT and ST all use the same set of codes; you must use therapy modifiers on 1500 claim forms to differentiate which therapy was performed.

- **GP**: Indicates services delivered under an outpatient physical therapy plan of care
- **GO**: Indicates services delivered under an outpatient occupational therapy plan of care
- **GN**: Indicates services delivered under an outpatient speech-language pathology plan of care

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Denial reasons

Claims denying for missing the appropriate modifier will have the following denial reasons:

- **O47 No modifier**: Please rebill with contracted modifier
- **M55**: Missing/Incorrect modifier

Medicare reduction in spending and new CAS code 253

(06-27-2016) As of June 28, Priority Health has used claim adjustment reason code CAS 253 instead of CAS 223.

In 2013, the Affordable Care Act required a 2% reduction in Medicare spending, also known as sequestration, for all Medicare Advantage health plans. Priority Health implemented this in 2013 with CAS code 223, and recently recognized the CAS code should instead be 253. You may see this new code on your explanation of benefits for Medicare services in place of CAS 223.

More information

See additional information about the Affordable Care Act and code 253 for a reduction in federal spending at *cms.gov*.

Chiropractic X-ray codes covered retrospectively

(06-16-2016) American Imaging Management (AIM), our third-party prior authorization tool for high-tech radiology, added procedure codes for scoliosis X-rays (72081 and 72082) as payable procedures to chiropractors on Jan 1, 2016. However, AIM did not load them properly in their system, so they were not actually being paid. AIM has corrected the error and Priority Health has also added these codes to our fee schedule.

Unpaid claims were automatically reprocessed

Claims for these codes that were not paid from January 1 until June 15 were reprocessed.

Billing lab claims for which you're CLIA certified

(06-06-2016) As of July 1, for all plans, participating providers may bill us for any laboratory test they are certified to perform according to their specific type of Clinical Laboratory Improvement Amendments (CLIA) certification on file with CMS. This may be beyond the set of laboratory codes listed in the Priority Health Provider Manual.

Requirements for billing

- Provider must participate with Priority Health
- Provider must be up-to-date with their CLIA certification
- Provider must include either their CLIA Certification Number or CLIA Certificate of Waiver number, as applicable, on claims
- The CLIA number included on claims must be the CLIA number on file with CMS

Find more information on CLIA, including the waived test list, at *cms.gov*.

More payments going electronic for enrolled providers

(05-25-2016) Providers who requested them began receiving all payments electronically as of June 12, including payments for self-funded plan members. Currently, electronic payments are only available for fully funded plan members. Checks will only be sent for special situations, such as PCP Incentive Program payouts.

There is no change for providers who have not elected electronic payments.

Choose electronic payments

You can choose electronic payments instead of checks by filling out an electronic funds transfer (EFT) setup request form. See instructions in the Provider Manual.

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Billing and payment

Medicare G0166 denials

(05-10-2016) Priority Health Medicare has been denying procedure code G0166 (external counterpulsation) as non-covered on facility claims in error since December 2015. The issue is in the process of being corrected, and any affected claims will be automatically reprocessed once the update is complete.

Payment error for some cochlear implant fittings

(05-09-2016) We have found a software error affecting cochlear implant fitting services billed as 92604 beginning Jan 1, 2016. Facility claims for Medicare, Medicaid and commercial patients may have been paid incorrectly or may have been denied payment for an incorrect status indicator.

The error has been corrected and we've reprocessed claims improperly paid or denied.

Pharmacy

Formulary change: Edits for all products, some effective Sept. 1

(08-01-2016) Priority Health's Pharmaceutical and Therapeutics (P&T) Committee has recently approved several updates to the approved drug list for all product lines. All edits can be found in the provider manual. For commercial products, many changes are effective Sept. 1.

Changes to the Priority Health Medicare Part D formulary will not take effect until Priority Health receives CMS's approval. For drugs covered by Medicare Part B, prescribers must follow WPS-Medicare local coverage determinations.

Changes to the Priority Health Medicaid formulary will be updated on a quarterly basis based on recommendations from the State's Work Group who manages the common formulary.

Formulary change: Advair and Breo will require step therapy

(05-31-2016) As of July 1, Priority Health has implemented a commercial formulary change for Advair and Breo. Both will remain non-preferred brand (tier 3). We require step therapy with one of our preferred drugs, Symbicort or Dulera, before coverage is allowed for Advair or Breo.

Why the change?

Advair/Breo are expensive drugs with lower cost alternatives that are just as effective. Priority Health offers these alternatives at a generic copay providing savings to the member and self-funded employers. This change is also in line with our Medicare formulary, which has required step therapy for Advair/Breo since Jan. 1, 2016. The Medicaid Common Formulary does not include Advair, but does cover Symbicort and Dulera.

How this affects members

- Members who have NOT had Dulera or Symbicort filled in the last year will be required to go through step therapy.
- Members with a claim for Dulera or Symbicort in the last year will have Advair/Breo automatically process without step therapy.
- Members on an open formulary may continue to receive Advair/Breo without step-therapy.
- Self-funded employer groups can choose to have their members grandfathered; step-therapy would not apply.

We're contacting members

We're contacting members currently taking Advair or Breo to let them know about this change.

Questions? Call the Pharmacy Call Center at 800.466.6642.

Medical policy updates

(07-06-2016) From time to time, we make changes to our medical policies. This list shows the policies that are new or have recently changed. All policy changes are posted to our website so you can review the changes before they go into effect.

The following policies received approval at recent Medical Affairs Committee meetings. For summaries of the changes and links to the updated policies, go to the Provider Manual Medical policies page.

New policies

- **Implantable Loop Recorder** – 91618, effective Sept. 12, 2016 (note: date change from July 15)
- **Endoscopic Submucosal Dissection** – 91617, effective June 13, 2016
- **Peroral Endoscopic Myotomy (POEM)** – 91616, effective June 13, 2016

Revised policies, effective July 29:

- **Vision care** – 91538

Revised policies, effective July 18:

- **High intensity focused ultrasound (HIFU)** – 91601

Revised policies, effective June 27:

- **Eating disorders** – 91007
- **Intracoronary brachytherapy** – 91536
- **Lumbar fusion** – 91590
- **Transcatheter heart valve procedures** - 91597

Revised policies, effective June 13:

- **Gastroesophageal Reflux Disease (GERD) and Barrett's Esophagus** – 91483

Revised policies, effective May 16:

- **Drug Eluting Stents for Ischemic Heart Disease** – 91580

Behavioral health/substance use disorder criteria transitioning to InterQual®

(06-30-2016) On Aug. 1, our medical policies for behavioral health services and substance use disorder began using InterQual® Criteria instead of custom criteria developed by Priority Health. This means our medical necessity criteria will align with nationally recognized decision support criteria.

The revised policies were posted in the Provider Manual > Authorizations > Authorization reference list Aug. 1.
You need to be logged in to your provider account to view these policies.

Impacted levels of care

This will impact all levels of care: inpatient, residential, partial hospitalization, intensive outpatient (IOP) and outpatient treatment.

Impacted plans

This change applies to group and individual commercial plans only. It does not apply to Medicare or Medicaid plans.

What are InterQual Criteria?

InterQual Criteria are evidence-based clinical decision support criteria developed by McKesson and used across the health care industry. They allow providers to use a standardized approach to assess each patient's unique situation and recommend the most appropriate care.

New hepatitis C drug preferred for commercial plan members

(06-17-2016) As of June 10, Zepatier™ replaced Harvoni® as the preferred drug for commercial plan members with a hepatitis C genotype 1 or 4 diagnosis. Harvoni was moved from the preferred to non-preferred category for commercial members. There is no change for Medicare members.

Why the change?

Clinical trials have shown that Zepatier and Harvoni have similar efficacy and safety profiles, but Harvoni costs

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approximately $40,000 more for a 12-week supply. This results in higher costs for patients and their employers with no added value.

How this affects members

This change only impacts members who are starting a new treatment. There are no changes for the members with hepatitis C currently taking Harvoni or other drugs.

This change only impacts commercial members. There is no change for Medicare members. The Medicaid Common Formulary does not include Harvoni or Zepatier.

Resources

Details of all bi-monthly formulary updates from the Pharmacy and Therapeutics (P&T) Committee can be found in the Provider Manual. Go to the Formulary updates. The prior authorization form for Zepatier outlines the authorization criteria for this drug. Find it on the drug auth forms section of our website.

Automatic online prior authorizations in development

(06-10-2016) We're working on a transition to a prior authorization automation tool called Clear Coverage™.

Clear Coverage will let you request authorizations online and receive immediate responses, including automatic authorizations for some procedures, making the authorization process quicker and easier.

We expect many prior authorizations to approve automatically along with faster approvals for those that need additional review. You'll be able to make requests and check the status of authorizations 24/7 using the new tool.

Eligible plans

Clear Coverage authorizations will be available for all Priority Health plans, including commercial group and individual plans, Medicare and Medicaid.

Outpatient procedures available first

There are no new policies or coverage changes. The tool will support our current outpatient service prior authorizations, including:

- Outpatient procedures
- Durable medical equipment (DME)
- Home care
- Physical, occupational and speech therapy

Inpatient authorizations are tentatively scheduled to move to the tool in 2017. The processes for high-tech radiology, behavioral health and drug authorizations will not change.

More information coming soon

Watch for more information and convenient online training opportunities.

Performance programs

2016 Quality Award recipients announced

(07-29-2016) This year, 176 physicians and practices in our network were recognized with the Priority Health Quality Award. These practices have achieved the highest overall scores for preventive care and chronic disease management while ensuring a good patient experience.

How recipients are selected

Recipients were selected after analyzing the results of the Priority Health Primary Care Provider Incentive Program which tracks clinical quality measures against national standards and evidence-based medicine. Our index sets high targets for how many children are immunized, how many adults are screened for cervical and colorectal cancer, and how patients have controlled their chronic conditions including diabetes and hypertension. Primary care physician practices earned $28 million in incentives in 2016 based on their performance in 2015.

Key success measures

The program's success is clearly demonstrated by the number of practices earning the primary care medical home (PCMH) designation as well as participants' demonstrated success in chronic disease care. By collaborating with physicians, Priority Health has successfully helped health plan members avoid incidence of chronic disease complications for conditions such as congestive heart failure, chronic obstructive pulmonary disease, diabetes mellitus, asthma and hypertension at rates better than state and national averages. Learn more about the Quality Awards and view the list of recipients at *priorityhealth.com/provider/news*.

Clinical resources

New lipid management clinic referrals

(05-10-2016) Priority Health has developed a network of lipid management clinics to help members who do not meet the clinical criteria for PCSK9 inhibitors manage their cholesterol or statin intolerance. We began referring to these clinics on June 13.

What lipid management clinics offer

If members choose to participate, they'll meet with a cardiologist or lipidoligist to receive a medical history review and to develop strategies to help them lower their cholesterol using statins and other lipid-lowering therapies. Our goal is to get patients the evaluation and treatment they need and back to their PCPs for ongoing care. Lipid management clinics have been shown to be effective for patients with statin intolerance[1].

Referrals to clinics

When a provider requests authorization for PCSK9 inhibitors (Praluent® or Repatha®) for a non-covered diagnosis, it triggers a referral for that patient to a lipid management clinic. Participation in the clinic is optional. We'll notify the provider that we're offering the member the option of a clinic visit. Providers may also refer patients to these clinics, even if a PCSK9 inhibitor was not requested. Participation in the clinic does not mean a member will be approved for PCSK9 inhibitors.

Coverage for PCSK9 inhibitors

For commercial group and individual members, these drugs are approved when there's a homozygous or heterozygous familial hypercholesterolemia diagnosis. For Medicare members, these drugs are covered when used for an FDA-approved indication. The drugs are not covered for Medicaid

[1]*Mampuya WM, Frid D, Rocco M, et al. Treatment strategies in patients with statin intolerance: The Cleveland Clinic experience. American Heart Journal. 2013.*

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Clinical resources

members at this time. See the drug authorization forms for complete coverage criteria.

Clinic locations and costs

Members can participate in on-site clinics at Spectrum Preventive Cardiology in Grand Rapids, or they may participate using a virtual visit with this clinic. More clinic options will be available soon. Visit our lipid management clinics list page for updates and contact information. Specialist office visit copayments, coinsurance and deductibles apply.

Joining the lipid management clinic network

Any provider who meets our criteria for lipid management clinics can request to participate and be added to our list of clinics. To meet the criteria, clinics must be:

- Led by a board-certified cardiologist or lipidologist
- Open to referrals of patients with lipid abnormalities or statin intolerance
- Experienced in the differential diagnosis of statin intolerance and managing re-institution of statin therapy in statin intolerant patients

To request inclusion email *PharmacyHelpDesk@priorityhealth.com*.

Responsibilities and standards

New provider directory validation required

(07-08-2016) Priority Health's online provider directory, **Find a Doctor**, is how our members, future members and referring medical practitioners find you. Do we have your practice information correct? Please review your information in **Find a Doctor** now.

Provider directory requirements

Provider directory regulatory bodies, including Medicare, Medicaid and NCQA, require health plans to communicate at least quarterly with providers and hospitals to ensure the accuracy of the provider directory information. Providers must review the following:

- Name
- Gender
- Specialty
- Hospital affiliation
- Medical group affiliation
- Board certification
- Networks the provider participates in, e.g.; HMO, PPO, Medicare, Medicaid (updated 8/9/16)
- Accepting new patients (PCP only)
- Languages spoken (by provider and staff)
- Office location and phone number
- Office hours
- Provider website address
- Accessibility for people with disabilities

We need at least 60 days notice for all provider information changes. This allows for adequate time for data validation and updating of our systems. Keeping your information up-to-date assures that members can reach you in a timely manner and your payments can reach you without delay.

If your Find a Doctor directory information is out-of-date

Email changes to your provider information to *PH-PELC@priorityhealth.com* using a Provider Change Form or other

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Responsibilities and standards

preapproved format. Or, for delegated entities, updates can be made through the monthly file submission process.

Compliance with notification requirements

Beginning in 2017, health plans will be severely penalized financially for misinformation displayed in their provider directory. As a result, providers who don't promptly notify Priority Health of changes to their information may be subject to future financial penalties and/or may be terminated from the network.

For example, you must notify us at least 90 days in advance of any practitioner's retirement or termination from your group practice. Notification requirements can be found in our Provider Manual.

We're exploring new solutions

We want to help reduce your administrative burden while maintaining an accurate provider directory for our members, which will allow them to make informed decisions regarding their care. We are looking into new processes and online tools that could allow providers to more easily manage information about their practices in our provider directory data. We anticipate being able to update you on this soon.

Aug. 9, 2016 update

Along with other Michigan health plans, we've selected the CAQH DirectAssure solution to assist us with provider directory regulatory compliance requirements. This solution allows you to update your information one time, through one source. The information is then distributed to all health plans who participate with the CAQH DirectAssure solution. You will be required to confirm that your provider directory information on CAHQ is correct every 90 days. We plan to have this implemented in October.

Plans and benefits

Long-term acute care to be covered by Medicaid

(07-28-2016) We will begin covering inpatient long-term acute care as a Medicaid benefit. Effective dates are based upon individual facility contract signing dates.

Reimbursement

Reimbursement is based on the medical surgical data DRG prices and per diem rates paid from the rehab unit per diem rate tab and the Medicaid capital history rate noted on the Medicaid website.

Outpatient rehab

At this time, outpatient rehab services for Medicaid LTACH are not covered.

Flumist Quadrivalent not covered for 2016/2017 flu season

(07-12-2016) The Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP) voted that live attenuated influenza vaccine (LAIV), which has a brand name of Flumist® Quadrivalent, should not be used during the 2016-2017 flu season. This decision was made because data from 2013 through 2016 shows this vaccine has poor or lower effectiveness. Priority Health follows ACIP recommendations for vaccines, so we're removing Flumist Quadrivalent from our list of covered vaccines.

Returns at no cost

The makers of Flumist Quadrivalent, AstraZeneca, are accepting returns at no cost to providers. Providers should contact their distributor.

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More details

Priority Health and the CDC continue to recommend annual flu vaccines. See the complete list of flu vaccines covered by Priority Health in the provider manual at *priorityhealth.com/provider*. For more details on Flumist Quadrivalent from the CDC, go to *cdc.gov*.

Get rewarded when you help patients achieve their HealthbyChoice goals

(06-30-2016) The results are in. Our employer-sponsored incentives-based **Health**byChoice® plans have successfully lowered employer costs and improved employee health.

A five-year study* concluded that **Health**byChoice members, when compared to similar members in non-wellness plans:

- Have a lower propensity for developing chronic diseases including atrial fibrillation, diabetes and lung disease.
- Saved employers up to 12% in claims costs or, on average, $60 per month. This reduction in health care costs helped save employers roughly $1.2 million over four years.
- Tend to make routine and preventive doctor visits. This offers you greater opportunities to nurture your doctor/patient relationships, creating an increased likelihood for high-quality care and lower cost.

How does the plan work?

HealthbyChoice plans reward members for being, getting and staying healthy. Participants can qualify for lower out-of-pocket costs when they meet certain health criteria.

How can you help?

Support your patients by completing their qualification form, and get rewarded in return.

- Network providers: Submit results online for a $30 reimbursement per form. Use the online qualification tool.
- Out-of-network providers: Print and fax qualification forms to Priority Health. The forms can be found on the provider forms page.

Referral process for Medicaid patients under 21 with severe BH issues

(06-27-2016) Effective Jan. 1, 2016, the Michigan Department of Health and Human Services (MDHHS) released a memo outlining a process for coverage of severe or specialized behavioral health services for children under 21 years of age. Read the memo at *michigan.gov*.

Refer to the local Community Mental Health office

After a child under the age of 21 is evaluated by their Medicaid primary care physician (PCP) and determined to potentially have a severe emotional disturbance, drug dependency or autism, the child needs to be referred directly to the community mental health (CMH) office for the member's county. The local CMH department will contact the child's parent(s)/guardian(s) to arrange a follow-up appointment for a comprehensive diagnostic evaluation and behavioral assessment.

Children with mild or moderate conditions (such as ADD or ADHD) do not need to be referred to a local CMH. Priority Health will cover up to 20 outpatient mental health visits.

Find local CMH offices, services

Find information about which agency or department handles specific services in the MDHHS responsibility grid at *michigan.gov*.

Medicaid Consumer Guide available

(05-20-2016) The Michigan Department of Health and Human Services (MDHHS) has published the 2016 Medicaid Health Plan Consumer Guide on their website. A hard copy of the guide is mailed to Medicaid members from a vendor when they first enroll in Medicaid and need to select a plan.

Research has shown that Medicaid beneficiaries use this document when making a plan selection and physicians also use it to make recommendations to their patients. This combination of referral reasons and our high ranking based on member feedback is why we feel it is important to get this document to the provider community, especially in our new region. The consumer guide can be accessed at *michigan.gov*.

**Study compared 4,153 members enrolled in HealthbyChoice Incentives plans to 4,106 standard non-wellness plan members with continuous enrollment from January 2010 - December 2014*

Provider network collaborative event slides and videos available

(07-27-2016) Our annual provider event, held June 7, brought together 120 network leaders to discuss the topic of paying for value. Joan Budden, Priority Health President and CEO, welcomed a line-up of expert speakers for the event. More than 93% of our attendees surveyed said the event was informative.

Slides and videos now available

You can now access and share the slides and watch the videos at *priorityhealth.com/provider/news*.

Priority Health Academy

(07-19-2016) Learn about the latest in health care and get important Priority Health updates at our Academy. It's an affordable, convenient opportunity to help you and your organization stay up-to-date and be successful.

New this year: We've lowered the price to $45. For that you get a full day of sessions, lunch and CEUs from the AAPC. Topics include:

- Billing and coding updates
- Working with Priority Health through credentialing, billing and payment
- Priority Health products
- 2017 Physician Incentive Program

Choose from three dates/locations

Traverse City: Tuesday, Oct. 4
Hagerty Conference Center at Northwestern Michigan College
8 a.m. to 3 p.m.

Southfield: Tuesday, Oct. 11
Hilton Garden Inn
8 a.m. to 3 p.m.

Grand Rapids: Wednesday, Oct. 19
Prince Conference Center, Calvin College
8 a.m. to 3 p.m.

For more information and to register, visit *priorityhealth.com/provider/news.*

Priority Health selected as part of CPC+ pilot program, PCPs can apply to participate through September 15

(08-02-2016) Priority Health has been accepted by CMS to participate in the Comprehensive Primary Care Plus Program (CPC+), a five-year model that begins January 2017. CPC+ is the largest-ever multi-payer initiative to improve the quality of care patients receive, improve patients' health, and spend health care dollars more wisely.

CMS program will redesign the care delivery system infrastructure and payment model

CPC+ is a national advanced primary care medical home model that aims to strengthen primary care through multi-payer payment reform and care delivery transformation. CPC+ brings together CMS, commercial insurance plans, and state Medicaid agencies to provide the financial support necessary for practices to make fundamental changes in their care delivery.

PCPs interested in participating must apply by September 15; CPC+ will provide learning system and data feedback

Primary care practices can apply for one of two tracks — one to build capabilities and one with incrementally advanced care delivery requirements and reimbursement.

Track 1:
Pathway for practices ready to build the capabilities to deliver comprehensive primary care.

Track 2:
Pathway for practices poised to increase the comprehensiveness of care through enhanced Health IT, improve care of patients with complex needs, and inventory of resources and supports to meet patients' psychosocial needs.

The application process is only open for 45 days.

Learn more

We encourage you to learn more about this initiative by visiting *cms.gov*.

PriorityHealth®
A healthier approach to health care®