PriorityHealth

Physician and practice news digest

Fall 2015

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Priority Health news

Register your online account at *priorityhealth.com* for full access to patient tools and incentive program information. Visit *priorityhealth.com/provider* to read this digest online.

REGISTER NOW FOR THE PRIORITY HEALTH ACADEMY

Register today. Space is limited and registration closes Oct. 9.

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.

There are two morning sessions—Billing and Coding Updates offering CEUs and Polarity Thinking offering nursing CEUs. The afternoon features expert speakers on telehealth and care management along with Priority Health product and incentive program updates.

Choose your date/location:

- Grand Rapids
  Wednesday, Oct. 21
  8 a.m. - 4 p.m.
  Prince Conference Center

- Traverse City
  Wednesday, Oct. 28
  8 a.m. - 4 p.m.
  Hagerty Conference Center

- Southfield
  Tuesday, Nov. 3
  8 a.m. - 4 p.m.
  Hilton Garden Inn

View the agenda, get a description of presentations and speakers, and register at *priorityhealth.com/provider.* **Search keywords:** Priority Health Academy

Billing and payment

Priority Health is ready for ICD-10

(08-04-2015) We have a dedicated team that has been working for more than a year to update and ready our systems for ICD-10. We've been actively testing for months with clearinghouses and providers. To date, we've been pleased with the success and smooth testing we've experienced and we're ready for the transition to ICD-10 on Oct. 1, 2015.

Will both ICD-9 and ICD-10 be accepted after Oct. 1?

- Claims for services with an Oct. 1, 2015, date and after must use ICD-10 coding as applicable.
- ICD-9 codes will only be accepted for dates of services of Sept. 30, 2015, and prior.
- Inpatient stays should be billed based on discharge date. Stays with a discharge date of Oct. 1, 2015 and after should be billed using ICD-10.
- Claims with the wrong ICD coding will be rejected for incorrect coding.

As always, claims should include diagnosis coding that is complete and to the greatest level of specificity. Documentation should continue to support the diagnosis code reported.

Education and information

We understand that there may be a need for additional learning during this transition period and we will work with providers as situations are identified.

We have dedicated ICD-10 information for providers at *priorityhealth.com/providers/news-and-education/icd-10*.

Here, you'll find:

- Library of the free ICD-10 webinar series
- Support and communications from Priority Health
- Resources and education tools

Dense breast law and mammogram billing

(06-02-2015) Public Act 517 of 2014 was signed into law on Jan. 10, 2015 and became effective as of June 1, 2015. The Act requires mammography facilities to provide specific information to a patient whose mammogram demonstrates heterogeneously dense or extremely dense breast tissue.

Initial screening vs. additional screenings/testing

Priority Health pays routine screening mammograms at 100% with no cost sharing since it is included in the standard preventive benefits. Any additional mammograms or testing needed to further explore a symptom or medical condition, including those of members with dense breasts, are considered diagnostic and will be covered according to the member's benefits - some copays, a deductible or coinsurance may apply. As of now, the US Preventive Services Task Force has not issued any recommendation stating that insurance companies need to cover additional dense breast screening services as preventive.

Explaining coverage to members: required language

Below is the communication that providers must now legally share word-for-word with any member whose mammogram yields results of heterogeneously dense or extremely dense breast tissue:

Your mammogram shows that your breast tissue is dense. Dense breast tissue is very common and is not abnormal. However, dense breast tissue can make it harder to find cancer through a mammogram. Also, dense breast tissue may increase your risk for breast cancer. This information about the result of your mammogram is given to you to raise your awareness. Use this information to discuss with your health care provider whether other supplemental tests in addition to your mammogram may be appropriate for you, based on your individual risk.

A report of your results was sent to your ordering physician. If you are self-referred, a report of your results was sent to you in addition to this summary.

If your patients have questions about what is covered under a routine screening, direct them to our preventive health care guidelines found at *priorityhealth.com/preventive.*

continued >

Billing and payment

Billing for e-visits with 99441-99444

(06-29-2015) As of July 1, 2015, the 99441 through 99444 telemedicine codes should be used for applicable services across all products. Do not bill G0425 with a GT modifier for Medicare.

Code descriptions:

- 99441, Telephone evaluation and management service by a physician or other qualified health care professional who may report E&M services provided to an established patient, parent or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
- 99442, Telephone services (see above), 11-20 minutes of medical discussion
- 99443, Telephone services (see above), 21-30 minutes of medical discussion
- 99444, Online medical evaluation - physician non-face-to-face E&M service to patient/guardian or health care provider not originating from a related E&M service provided within the previous 7 days

See the “Procedures and services” > “Phone and e-visits” section of the Provider Manual for more telemedicine billing and coding information.

Take-backs and credit balance forward tracking

(06-08-2015) We have updated the Provider Manual to clarify how Priority Health processes take-backs and credit balance forwards. These bullet points have been added to the billing and payment section of the online provider manual:

- The take-back amount will appear as a negative payment on the remittance advice that is offset with dollars being paid on another claim for a member with the same plan (HMO, POS, PPO, etc.). If no further claims are paid from the same plan, Priority Health may attempt to collect the funds from payments on another Priority Health plan.
- Each self-funded (SF) group is its own line of business, so Priority Health will first attempt to take back dollars from a paid service to the same provider for another member in the same group.

Pharmacy

Medication Therapy Management program extended to group plan members

(05-27-2015) Based on success with our Medicare members, the Medication Therapy Management (MTM) program has been expanded to serve fully funded and self-funded employer group plan members. We're the only health plan in Michigan offering this service.

MTM consultations are available through most large chain and many local pharmacies to qualified members who take four or more chronic condition medications or who have gaps in care for medications. This includes members who are non-adherent to chronic medications or who may not be taking a medication that is recommended in evidence-based guidelines. The program is currently not available to Medicaid members.

We've announced the program benefits to members. Pharmacists will now make outreach calls and set appointments with qualified members.

MTM reviews solve problems, save money

Initial results from our Medicare members show that, on average, two drug-related problems are resolved for each patient engaged in the program, and for every $1 invested in pharmacist-provider MTM some $4 is saved in medical costs.

As always, primary care providers remain the center of the patient's medical home. We simply ask that you engage with the pharmacist regarding suggested medication changes and summary medication lists to serve the best interests of your patients. Working together, we can improve the health and lives of our members by making sure they get the best results from their medications.

During the MTM medication review

At the 30-45 minute MTM medication review, the pharmacist reviews the member's medications and:

- May suggest alternative drugs to help relieve side effects
- Helps the member understand their drugs and how to take them
- Assists the member in organizing their medicines and medication schedule
- Suggests equivalent generics over brand name medications when appropriate

After the review, the pharmacist will work with the member's doctor to make changes that address gaps in care.

Affordable brand-name diabetes, asthma and COPD drugs

(06-30-2015) To support our many members living with chronic conditions we continue to make certain brand name drugs and testing supplies more affordable. Since July 2009, Priority Health members have had access to select maintenance drugs and supplies at generic copay on the commercial formulary. We're the first health plan in Michigan to offer this for all commercial members. Below is the list of our more affordable offerings.

Diabetes medications

- Lilly Brand (Humulin and Humalo) insulins – both commercial and Medicare formulary
- Lantus insulin – commercial formulary
- Lifescan (e.g. OneTouch) test strips – commercial formulary only
- Bayer (e.g. Contour and Breeze) test strips – commercial formulary only

continued >

Pharmacy

Asthmas/COPD medications – commercial formulary only*

- QVAR inhaler
- Pulmicort inhaler
- Symbicort inhaler
- Dulera inhaler

*Changes in 2016 for Medicare

Additionally, in the Clinical resources section of *priorityhealth.com* we offer asthma and diabetes clinical practice guidelines, practice management and patient education tools to help you help your patients.

Reminder: Formulary updates

(06-02-2015) The Pharmacy and Therapeutics Committee meets every other month to review the Priority Health formulary. Our pharmaceutical management procedures are reviewed annually. Both are available online in the "drug auths" section of the Provider Manual.

How to get a copy of our formulary

The updates are available at *priorityhealth.com/provider.*
Search keywords: Printable drug list

Questions about utilization management decisions and processes?

Physician and pharmacist reviewers are available to help you. Call the Priority Health pharmacy department at 800.466.6642.

Reminder: Adverse Drug Event? Call MedWatch

(06-15-2015) If a patient experiences an adverse drug event, product problems or product use errors; we encourage you to report it to MedWatch by:

- Calling 800.FDA.1088 (800.332.1088); or
- Submitting the MedWatch 3500 form by fax or mail; or
- Using the MedWatch Online Voluntary Reporting Form at *fda.gov/medwatch*

Reminder: Medicare formulary exception process

(06-15-2015) For drugs that are not on our Medicare formulary or that require utilization management (e.g. prior authorization, step therapy, quantity limits), you can request an exception to coverage if the covered alternatives won't work or have not worked as well for the member.

All Medicare prior authorization forms ask you to supply supporting evidence/documentation when requesting an exception. When evidence/documentation is provided, we will use this information in determining if the request is medically necessary. If the evidence/documentation is not received, requests will not be approved.

Reminder: Answers to questions about pharmacy benefits

(06-15-2015) Pharmacy benefits among Priority Health members can vary based on the coverage purchased. Here are answers to some frequently asked questions about Priority Health pharmacy benefits:

Pharmacy

Q: Who determines the copay the patient pays?
Priority Health offers employers many different options for pharmacy coverage. The employer or purchaser analyzes the options and makes the decision. The level of copay affects the total cost of health care coverage for which the employer is responsible. Pharmacy coverage is an essential health benefit for all small group plans but large employers (those with 50 or more employees) can elect not to cover prescriptions.

Q: What are flat, two-tier and three-tier copays? Or specialty drug copays?
A flat copay is when the patient pays the same fixed dollar amount for the copay independent of whether the prescription is for a brand-name or generic product.

The two-tier copay is when the patient pays the lower copay if the prescription is filled with a generic medication or a more expensive one if it is for a branded product. Patients with two-tier coverage have access to non-preferred products if their condition warrants their use and is medically necessary.

A three-tier copay is similar to a two-tier copay for the two lower copay levels. The third tier is for non-preferred products. The non-preferred agents on the third tier will always require payment of the third-tier copay.

Some members will pay more for specialty pharmacy drugs, including those administered in the physician's office or infusion center. Specialty drugs are classified as preferred specialty (fourth tier) or non-preferred specialty (fifth tier). Preferred specialty drugs typically have a lower copay than non-preferred specialty.

Q: Why can one patient have a different copay than another patient?
Priority Health offers many pharmacy benefit choices: employer-sponsored (commercial), Medicaid and Medicare. Employer-sponsored plans have many different options for coverage and copay. Priority Health Medicaid members are covered under a formulary that is similar to the standard, closed formulary, although the State of Michigan may require some coverage that is not part of the standard commercial benefit. Priority Health Medicare members typically have a four-tier copay, though some Medicare plans provided by an employer may choose to have a two-tier copay.

Q: Do you cover birth control pills or drugs for erectile dysfunction?
Due to the Affordable Care Act, contraceptives for women are a covered benefit for non-grandfathered health plans. Contraceptive coverage can be excluded by religious employers. Drugs to treat erectile dysfunction are only covered if the employer has selected a rider that provides coverage for these drugs. If either of these options is selected by the employer, the appropriate copay will apply to the prescription. Medicaid and Medicare plans cover contraceptives but do not cover drugs for erectile dysfunction. Certain employer-sponsored Medicare plans choose to add coverage for erectile dysfunction drugs.

Q: How has the Affordable Care Act impacted pharmacy benefits?
In addition to the changes for contraceptive coverage noted above, coverage for several medications has been classified as preventive. These drugs are covered at 100% to members in a non-grandfathered health plan. Covered drugs include tobacco cessation medications, breast cancer preventive medication and low-dose aspirin to prevent heart disease in adults. For a complete list of these medications, review the Priority Health Preventive Health Care Guidelines.

Q: What other limits apply to the pharmacy benefit?
Priority Health limits coverage to a maximum 31-day supply per prescription. Mail order prescriptions may provide up to a 90-day supply of medication for either one, two, or two and a half copays. And many of the pharmacies in our network participate in our "90 day at retail" program, allowing members to fill a 90-day supply for three copays at a local, retail pharmacy. Medicaid members are not eligible for 90-day fills. Most specialty drugs must be obtained from a network specialty

continued >

Pharmacy

pharmacy for commercial members. Priority Health may also use specific prior authorization criteria for some prescriptions, as well as quantity limits based on clinical data or cost-effectiveness. Some drugs also require step therapy.

If you have questions about pharmacy benefits, contact the pharmacy call center at 800.466.6642

Reminder: Drug auths after hours

(06-15-2015) When a member presents a prescription for an urgent drug that requires prior authorization after Priority Health has closed, pharmacies are encouraged to provide the patient with a starter supply of the drug. Priority Health covers up to seven days of medication to assure the member does not go without therapy while waiting for prior authorization. Pharmacies are encouraged to reach out to provider offices the next business day to notify the office that prior authorization is needed.

Reminder: Step therapy required for select drug categories

(06-15-2015) Within the Priority Health commercial formulary some drug categories require step therapy, or the therapeutic trial of an alternative drug or drugs before authorization is granted for the originally requested medication.

The following drug classes require step therapy:

Celebrex
Celebrex requires documented trial with two of the following NSAIDs:

- Meloxicam (Mobic)
- Diclofenac (Voltaren)
- Nabumetone (Relafen)
- Etodolac (Lodine)

Prior authorization is available for members who are at high risk for a GI bleed.

Antidepressants
Brand-name antidepressants require documented trial with at least one generic antidepressant first.

Antipsychotics
Brand-name antipsychotics require a documented trial with at least one generic atypical antipsychotic.

Triptans
Brand-name triptans for treatment of migraine require a documented trial with at least one generic triptan.

Reminder: Availability of physician and pharmacist reviewers

(06-15-2015) Questions or concerns regarding our utilization management decisions can be referred to your Provider Account Representative or the pharmacy department at 800.466.6642. We may use physician and pharmacist reviewers to assist you.

Performance programs

June update to 2015 PCP Incentive Program

(06-25-2015) Go to the Provider Manual > Performance programs > PCP Incentive Program to download our June update to the 2015 PCP Incentive Program Manual and measures chart.

We've revised the chart with newly–released commercial, Medicare and Medicaid target numbers, as well as CPT and HCPCS codes, and added administrative details and reference links for several measures.

Targets added to the manual

- **Page 28** Diabetes Care: Hypertension Medication Therapy
- **Pages 30-31** Hypertension: Controlled Blood Pressure
- **Page 39** Emergency Department Visits: PCP Treatable Care

Additional changes on pages

We clarified language and added acceptable codes on existing measures. We suggest printing a new copy of these pages to update your hard copy.

- **Page 5** How we audit data
- **Page 15** Well-Child Visits in the First 15 Months of Life
- **Pages 37-38** Care Management (Added 99490 to the acceptable code list)
- **Page 44** Measure codes for Depression Screening

At Priority Health, we continue to reward prevention, improved clinical outcomes and the delivery of cost-effective care. This year's program supports your efforts to provide the best clinical care while balancing cost and patient experience - a structure that directly reflects the Triple Aim.

Questions?

Contact your Provider Account Representative. They can help you meet your program objectives.

Plans and benefits

In-home health assessments offered to some My**Priority** and Medicare members

(05-27-2015) Priority Health will be offering in-home health assessments to some of our members with Medicare, individual or small group coverage. Visits will be conducted by board-certified physicians through CenseoHealth, a national provider of in-home health assessments. These in-home assessments, which are optional and provided at no additional cost to members, help us ensure that we are adequately managing our members' health risks and providing them with appropriate care management.

These in-home health assessments are conducted in accordance with the Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS) and the Affordable Care Act (ACA).

What happens at these visits?

The visit is intended to support you and your patients in the care they receive. Censeo physicians will be collecting data only. They will not provide care or change a patient's current care plan.

During an assessment, a board-certified physician checks the member's vitals, reflexes and blood pressure, and then performs a consultative review of the member's current health, medical history and medications. After the assessment, we'll provide members with a checklist of items they may want to discuss with their doctor.

You'll receive a summary

If you have patients who receive an assessment, we'll provide you with a summary of the findings, so you have all the information in a report for your patient's next visit.

Questions?

If you have any questions, feel free to contact CenseoHealth at 877.868.5351 or, contact your Priority Health Provider Account Representative directly.

2016 Changes to preventive health care guidelines

(08-07-2015) Our health plans cover preventive services as outlined by the Affordable Care Act and recommended by the U.S. Preventive Services Task Force, the Centers for Disease Control and Prevention and the Health Resources and Services Administration. By following these guidelines, we're making sure the care we recommend and cover as preventive is safe and effective according to the latest medical research.

Note that Medicare has separate guidelines for preventive services covered for Medicare Advantage patients. You can always find information on both our Guidelines and Medicare preventive care:

- At *priorityhealth.com/preventive*
- In the Members area of *priorityhealth.com* both as web pages and printable PDFs

Also see our online Provider Manual for coding and billing help for preventive services

Digital breast tomosynthesis will be covered 1/1/ 2016

Beginning Jan. 1, 2016, we will cover digital breast tomosynthesis (DBT) for breast cancer screening at 100% in response to the dense breast notification legislation recently passed in our state. However, this screening is available to all women who fall within the breast cancer screening guidelines. We encourage doctors who believe their patients would benefit from DBT to ensure they visit an imaging center that has the equipment to perform this service.

Coverage notes: Covered once every 2 years for women ages 50-74. Begin at age 30 for those at high risk or at your doctor's discretion.

Plans and benefits

Changes to the guidelines in 2015

These changes to the 2015 Preventive Health Care Guidelines were added earlier this year. Services will be covered with no cost-sharing for all non-grandfathered commercial plans. Cost-sharing will apply for these services when a member is in a grandfathered plan.

These guidelines do not apply to Medicare. Medicaid and Healthy Michigan follow the preventive health care guidelines, except for Cologuard®, which is excluded at this time.

Cologuard colorectal cancer screening, effective 2/1/2015

Note that colonoscopy remains the "gold standard." Beginning at age 50, both men and women at average risk for developing colorectal cancer should begin screening. Not covered by Medicaid or the Healthy Michigan Plan.

Fluoride varnish, effective 5/1/2015

Fluoride varnish applied in the PCP/pediatrician office to the primary teeth of children up to age 5.

Hepatitis B screening, effective 5/1/2015

Hepatitis B screening for nonpregnant adults and adolescents at high-risk.

Women's contraceptives, effective 7/1/2015

Generic contraceptive methods and the ring methods for women are covered at no cost to the member. Deductible and/or prescription copayment applies for brand-name contraceptives when there is a generic available.

Cardiovascular counseling, effective 8/1/2015

Healthy diet and physical activity counseling to prevent cardiovascular disease (CVD) for adults with CVD risk factors (obesity).

Preeclampsia prevention, effective 9/1/2015

Preeclampsia prevention: aspirin is now included in the Preventive Health Care Guidelines

Reminder: Home light therapy coverage for psoriasis

(07-16-2015) Certain drugs used to treat psoriasis require a documented trial of UVB phototherapy before the drug will be authorized.

When home light therapy units are covered

If your patient is unable to receive UVB phototherapy in a dermatology office because it is not within a reasonable driving distance or because the member works during office hours, your patient may qualify for a home light therapy unit. For more information go to *priorityhealth.com*.
Search keywords: Skin conditions medical policy

Prior authorization required

The home light therapy unit is covered as part of durable medical equipment (DME) benefits for most commercial and Medicare members. A prior authorization is required before the member can receive their home light therapy unit. See the DME authorization page for more information and the prior authorization form at *priorityhealth.com*.

Reminder: Medicare patient referrals to out-of-network providers

(06-01-2015) According to the Medicare Managed Care Manual Chapter 4, Section 170, and your Priority Health contract, if you need to refer a Medicare member to another provider, you must choose a participating (in-network) provider if available and medically appropriate. If you must refer a member to an out-of-network provider, you must notify the member that the provider you're referring him/her to is not in their network.

Questions?

Refer to the Medicare Managed Care Manual, section 170.

Responsibilities and standards

Medicaid PCPs encouraged to enroll in CHAMPS

(06-17-2015) The Michigan Department of Health and Human Services (MDHHS) has asked Priority Health to encourage all Medicaid primary care physicians (PCPs) to enroll in the Community Health Automated Medicaid Processing System (CHAMPS). If minimum enrollment is not met, enrollment will be made mandatory by MDHHS and CMS.

Incentive to enroll in CHAMPS

- Medicaid members will soon use CHAMPS to select their PCP
- Only CHAMPS-enrolled PCPs are eligible to receive their PCP-IPP incentive

Additionally, each PCP is asked to enroll so CHAMPS may screen for ineligible providers (debarred, criminal convictions relating to health care fraud, etc.). These screenings are required by federal law to protect against fraud, waste and abuse.

To enroll in CHAMPS

To enroll in the CHAMPS system, visit the main CHAMPS page at *michigan.gov.*

Gaps in behavioral health care continue

(08-05-2015) We recently reported Priority Health 2015 HEDIS rates for data year 2014 to the National Committee for Quality Assurance (NCQA). Our goal for 2014 was to meet or exceed national 90th percentiles. Thanks to your commitment to patient care some of our rates did improve, but only five met our goals. See results below, including a two-year performance look-back.

Areas for improvement

We achieved performance goals in five measures. Scores declined in five measures and showed no improvement in eight others. There is more work to do together to improve gaps in care for those accessing mental health services. If you have questions about the following HEDIS measures, email *karen.navis@priorityhealth.com*.

NR indicates we are not required to report a rate to NCQA as these are services that are carved out by the State of Michigan.

Follow-up after hospitalization for mental illness

7-day phase:

The percentage of mental health hospital discharges for which the member received a follow-up visit with a mental health provider within 7 days of discharge.

HMO/POS		PPO		Medicare		Medicaid	
2014	2015	2014	2015	2014	2015	2014	2015
61%	61%	58%	66%	44%	48%	NR	NR

30-day phase:

The percentage of mental health hospital discharges for which the member received a follow-up visit with a mental health provider within 30 days of discharge.

HMO/POS		PPO		Medicare		Medicaid	
2014	2015	2014	2015	2014	2015	2014	2015
81%	81%	71%	75%	71%	77%	NR	NR

Antidepressant medication management

Effective acute phase:

The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks) from first dispensing.

HMO/POS		PPO		Medicare		Medicaid	
2014	2015	2014	2015	2014	2015	2014	2015
73%	73%	71%	69%	78%	78%	58%	62%

Responsibilities and standards

Effective continuation phase:
The percentage of members who remained on an antidepressant medication for at least 180 days (6 months) from first dispensing.

HMO/POS		PPO		Medicare		Medicaid	
2014	2015	2014	2015	2014	2015	2014	2015
54%	53%	53%	51%	61%	63%	42%	48%

Alcohol and other drug dependence (AOD) treatment

Initiation phase:
The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

HMO/POS		PPO		Medicare		Medicaid	
2014	2015	2014	2015	2014	2015	2014	2015
38%	37%	38%	33%	45%	45%	NR	NR

Engagement phase:
The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

HMO/POS		PPO		Medicare		Medicaid	
2014	2015	2014	2015	2014	2015	2014	2015
13%	13%	9%	9%	5%	7%	NR	NR

Follow-up care for children prescribed ADHD medication

Initiation phase:
The percentage of members 6-12 years of age with an ambulatory prescription dispensed for ADHD who had one follow-up visit with practitioner with prescribing authority during the 30-day initiation phase.

HMO/POS		PPO		Medicare		Medicaid	
2014	2015	2014	2015	2014	2015	2014	2015
36%	37%	37%	41%	NA	NA	33%	34%

Continuation and maintenance phase:
The percentage of members 6-12 years of age with an ambulatory prescription dispensed for ADHD who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended.

HMO/POS		PPO		Medicare		Medicaid	
2014	2015	2014	2015	2014	2015	2014	2015
38%	40%	46%	52%	NA	NA	30%	30%

Training opportunities

Register now for the Priority Health Academy

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

The Academy will be held in three cities:

- **Grand Rapids** Wednesday, Oct. 21
- **Traverse City** Wednesday, Oct. 28
- **Southfield** Tuesday, Nov. 3

View the agenda, get a description of presentations and speakers, and register at *priorityhealth.com/provider*.
Search keywords: Priority Health Academy

Fall Virtual Office Advisory Forums

(08-18-2015) Mark your calendar and join us for the remaining fall 2015 Virtual Office Advisory forums. These lunch hour sessions provide you with an opportunity to hear from Priority Health experts about network updates, new programs, educational opportunities and more.

Fall 2015 virtual office advisory forums
Noon to 1 p.m.

- Wednesday, Oct. 14
- Wednesday, Nov. 18

Watch for an email invitation with a registration link for the next session soon. If you don't receive emails from us and would like to stay informed electronically, go to *priorityhealth.com* and click **Register**. The account verification process takes up to five business days.

Priority Health news

Members can earn financial rewards by being engaged health care consumers

(06-10-2015) With the debut of a program called **Priority**Rewards, Priority Health is leading Michigan with an innovative solution that rewards members for choosing to receive care at high-quality, lower-cost facilities. As of July 1, 2015, Priority Health offers a financial reward to all commercial members who use the Cost Estimator tool available at *priorityhealth.com* and in our app to choose a lower-cost option for select health care services.

As patients face higher out-of-pocket costs, Priority Health has published the prices of more than 300 health care procedures—including MRIs, lab tests and surgeries to help members save money and plan for health care expenses. Now, when a member uses the tool and has a procedure performed at a facility with pricing at or below the fair market rate, the member will receive a Visa® reward card in the mail. **Priority**Rewards is not available to members in government programs.

This initiative is a significant step in Priority Health's drive to reduce health care costs through transparency and member engagement. As providers, you can help by encouraging your patients to get engaged in their care and by performing procedures at fair market-priced facilities.

Learn more about our cost and quality transparency tools at *priorityhealth.com/provider/news-and-education/transparency.*

Priority Health designated as Michigan's benchmark

(07-16-2015) The Department of Insurance and Financial Services (DIFS) just released a report recognizing the Priority Health HMO plan as Michigan's 2017 Essential Health Benefits Benchmark Plan. This is the second time we have received this distinction. Priority Health first earned the honor in 2012 and represents the only health plan in the state of Michigan to ever earn this designation. Priority Health continues to set the bar for all health plans to follow.

An executive report released by DIFS on July 1, 2015, stated: "DIFS believes that the selection of the Priority Health HMO plan achieves the best balance between comprehensiveness and cost-effectiveness for Michigan consumers." The report goes on to say, "The Priority Health HMO plan offers a wide range of benefits and will provide an excellent framework for all individual and small group plans offered in Michigan for plan year 2017."

What is a benchmark plan?

Through the Affordable Care Act, DIFS is required to select an Essential Health Benefits plan for all other health plans to model every five years.

DIFS selects the plan based on its ability to include coverage for all Michigan-mandated services and provide comprehensive coverage while maintaining affordability. In addition, DIFS also took into consideration public comments, scope and duration limitations for covered benefits and consistency with the current benchmark plan.

The DIFS recommendation is shared with CMS who will make the final determination on the Essential Health Benefits Plan. This is expected to come out later this month.

Check out the complete report and see a copy of the letter of recommendation from Governor Rick Snyder at *michigan.gov.*

PriorityHealth

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