PriorityActions FOR PROVIDERS

March 7, 2024
Issue #2.5

Welcome to our biweekly PriorityActions for providers, where you'll receive important information to help you work with us and care for our members.

You're receiving this email because you're a part of an Accountable Care Network (ACN) or Provider Organization (PO) with us. Please share relevant information with your provider groups and practices. Your Provider Strategy & Solutions consultant remains your primary contact for support.

PLANS AND BENEFITS

New PriorityBABY program now available: all Priority Health babies welcome

PriorityBABY™ is a program designed to support children and their caregivers during a child's first two years. It is a continuation of the successful PriorityMOM™ program and includes health care information, gifts and incentives.

What are the program's goals?

- Promote essential preventive care for children up to age two
- Inform caregivers about Priority Health coverage and benefits
- Reduce the number of avoidable emergency visits
- Increase vaccination rates
- Increase lead screening rates

- Extend the PriorityMOM journey by supporting the physical and mental wellbeing of parents and caregivers
- Increase access to essential resources

What does the PriorityBABY journey look like?

1. **Invitation.** A dependent baby (up to six months old) being added to a Priority Health plan is the trigger for an invitation to the program. The caregiver must opt in.
2. **Welcome Gift.** This includes a forehead thermometer, a baby bath thermometer, a milk/formula cooler storage bag, wet/dry bags and a program overview.
3. **Next Best Action emails.** The caregiver will receive monthly emails that focus on appropriate health care for the baby, appointment reminders and resources, important cost and coverage information, safety education and infant support.
4. **Survey and gift.** At the baby's first birthday, the caregiver will fill out a survey and receive another gift if they attended three or more well-child checkups in the first year.
5. **Year two.** PriorityBABY continues providing caregiver and baby support in the baby's second year of life. The program ends with a final survey and gift.

Who's eligible?

All Priority Health members on commercial (group and individual) and Medicaid with a child under six months old can opt in.

How can providers help?

1. Inform pregnant members about our PriorityMOM program.
2. Encourage members to enroll in the PriorityBABY program after delivery.
3. Refer members to our customer service team for questions about coverage/benefits.

REQUIREMENTS AND RESPONSIBILITIES

New medical exam requirements for Medicaid members in foster care

The Michigan Department of Health and Human Services (MDHHS) released new medical exam requirements for Medicaid health plans and providers serving children in foster care.

These new requirements go into effect in March. With roughly 10,000 children in foster care at any given time, PCPs could see an increase in scheduling demand.

New MDHHS requirements

1. **Medicaid beneficiaries in foster care must complete a medical exam within 30 days of entering foster care.** This exam is required and will be covered at no cost to the member, regardless of the date of their last medical exam.

   Additionally, children in foster care require the following services:

   - **Ages 0-20 years**: All appropriate medical exams (EPSDT or Well-Child Exam) for their age
   - **Ages 3 years and older**: Dental exam within 90 days of entering foster care unless the child had a dental exam within six months prior to the date

   Our care management team is actively involved in reaching out to foster parents or caregivers to schedule needed exams within the MDHHS timelines.

2. **Health plans must allow Medicaid members in foster care to maintain their current PCP.** This applies to PCPs within a reasonable distance of the member's foster care living arrangement, for both in and out-of-network providers.

2024 PIP reports to show Medicaid members' foster care start dates

To support compliance with these new guidelines, we added Medicaid members' foster care eligibility (start) dates to the following PCP Incentive Program (PIP) reports:

- HEDIS Gaps in Care (PIP_11C)
- Membership Eligibility (PIP_075)

You'll see this information at the end of each report in a column titled "Medicaid Foster Eligibility Date" when the 2024 PIP reports are

released in April.

Medicaid providers: Make sure your Primary Specialty is entered in CHAMPS

To align with MDHHS, we're updating our Medicaid edit 5169 to more accurately validate claims from providers enrolled in CHAMPS as "individual/sole proprietor." The edit will reference the CHAMPS provider enrollment form's Primary Specialty field to determine whether a provider is an approved provider type.

If the Primary Specialty field isn't filled in when the edit logic is updated, providers will see an increase in front-end rejected claims.

We're aiming to have the edit's logic updated in the next 90 days and will send a follow-up communication with the exact date.

Fewer requests for providers to reimburse inaccurate payments
Medicaid edit 5169 rejects claims for "non-approved provider types" found in the Attending, Ordering or Referring fields for claims submitted by those registered in CHAMPS as individual/sole proprietors.

The state's 5169 edit validates provider type using CHAMPS Primary Specialty field. This data was recently made available to health plans. Aligning our data sources for this edit with the state's will lead to:

- More accurate validation of Medicaid-approved provider types on the claims
- Fewer claim rejections from the state
- Fewer requests for providers to reimburse inaccurate payments

What do providers need to do?

We ask providers enrolled in CHAMPS as "Individual / Sole Proprietor" to verify the following before submitting claims for Medicaid members:

1. They're active in CHAMPS on the date of service.
2. Their Primary Specialty in CHAMPS is complete and an approved provider type.

Providers seeing an increase in 5169 front-end rejected claims after the edit's logic is updated should verify the above and then resubmit their claims.

Note: Medical necessity review doesn't verify provider type

Providers with approved authorization requests for Medicaid members may still see claim denials if their CHAMPS Primary Specialty isn't filled out or isn't an approved provider type.

INCENTIVE PROGRAMS

Our updated 2024 PIP Manual now available

We recently updated our 2024 PCP Incentive Program (PIP) manual.

ACCESS THE 2024 (PIP) MANUAL

(login required)

Here's a summary of the changes:

Page 6: 2024 program measure grid

The commercial 90th percentile target was incorrect in the manual. The correct target is 46%

Page 19: Social Determinants of Health Screening

Added an additional screening code (G0136) that will count as numerator compliance.

Page 42: Appendix 5: Report inventory

Added Medicaid members' foster care eligibility (start) dates to the following PIP reports:

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- Membership Eligibility (PIP_075)

Removed CCDA and MiHIN PPQC data submission verification as available confirmation reports. These reports are not available currently.

Page 43: Appendix 6: Appropriate statin use in diabetic patients

Updated measure and medication information and tips for success.

Page 46: Appendix 7: Medication adherence in patients with diabetes, hypertension and high cholesterol

Updated measure and medication information and tips for success.

April’s PRA attestation is underway

Our April Provider Roster Application (PRA) cycle is currently underway. Attestation for April PCP rosters closes on March 15.

ACNs participating in any of the following programs must attest to their PCP rosters monthly:

- PCP Incentive Program (PIP)
- Alternative Payment Models (APM)
- Disease Burden Management program (DBP)

Save time with PRA’s batch upload feature.

As a reminder, All ACNs that currently attest in PRA can batch upload group/subgroup details, rather than entering information for each individual practice or provider.

Learn how on page 14 of the PRA Manual.

ACCESS THE PRA MANUAL

(login required)

AUTHORIZATIONS

Reminder: Acute inpatient authorization denial calls to facilities will stop April 8

As we shared last month, our utilization management team will soon stop calling facilities to notify them of most acute inpatient authorization denials.

Effective April 8, facilities will need to look to GuidingCare for these denials.

These decisions along with denial letters are already available in the authorization portal's Authorization List area.

This change won't impact decision turnaround times.

GET MORE INFORMATION

BILLING AND PAYMENT

Professional providers: POS 02 virtual care services reimbursed at facility-based rate starting May 1

Effective May 1, 2024, we're aligning with CMS on our reimbursement rate for professional virtual care services based on the reported place of service (POS) code.

POS code	Reimbursement	Products impacted*
02 Telehealth provided other than the patient's home	Reimbursement will be updated to the **facility-based** fee schedule rate.	Commercial, Medicare
10 Telehealth provided in the patient's home	Reimbursement will continue to be at the **non-facility-based** fee schedule rate.	Commercial, Medicare
**Medicaid will also be updated to align with the state of Michigan's reimbursement rates for virtual care.*		

Why are we making this change?

This update aligns with CMS's recent reimbursement changes that went into effect on Jan. 1, 2024.

Questions? Connect with your Provider Strategy & Solutions consultant, Anita Wallace.

Priority Health

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