Priority Health

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PriorityActions
FOR PROVIDERS

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

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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.

PRIORITY HEALTH

Get our Q3 Physician and practice news digest and our Q3 Medicare/Medicaid Quality newsletter

Our summer 2024 Physician and practice news digest and our Q3 Medicare/Medicaid Quality newsletter are here.

These newsletters are sent to our ACN contacts and all providers with a prism account who have opted in to receive our communications. They include our latest news and updates, and share information and ideas to help our providers work with us and provide the best care for our members.

Did you miss last quarter's newsletters?

You can find newsletters from 2024 and beyond in our Provider news archive.

Take action today before your staff loses access to prism

Our annual prism Security Administrator (pSA) renewal period is underway. By **August 1**, pSAs need to review and either approve or deny all user affiliations for your group or facility so that they don't lose access to essential data.

If you are a pSA and haven't completed your review, please do so now.

If you aren't a pSA, please check to make sure your group's pSA has completed the review.

What exactly is happening?

Each provider group and/or facility needs a pSA to control access to data like claims, authorizations and appeals. pSAs control access by approving or denying affiliation requests. During this annual pSA renewal period, pSAs review affiliation requests they've already approved to make sure each user's access is still needed.

If a user's affiliation is renewed by their pSA, nothing will change for that user. If a user's affiliation is denied, that user will lose access to all of that group or facility's data.

Important: If users aren't renewed, they'll automatically be removed from the provider affiliation after August 1. It's important for pSAs to review all renewals and take action to ensure access isn't disrupted.

Why is this important?

Data security is a top priority in the health care industry, now more than ever. The high job turnover rate in the health care industry creates a potential vulnerability in data security. Requiring pSAs to review their affiliated users annually is a simple and quick way to safeguard provider data and protected health information (PHI) by ensuring individuals who leave their organization no longer have access to their data.

How do I complete the pSA renewal process?

If you're a pSA, follow these steps between June 1 and August 1:

1. In your prism account, select **Security Administration**, then **Affiliation Requests**.
2. Navigate to your Affiliations table and select **Affiliation Renewals** at the far right of the table.
3. Review the users currently affiliated with your provider group/facility and determine if they should be renewed. Once you select the user by checking the box, an **Approve** or **Deny** button will appear. Note: you can select multiple users at one time to approve or deny.
4. Confirm your selection.

Unsure if the users are still employed by your organization or need to check with another department before you renew? You can select **Download Pending Renewals** to get an Excel sheet to share with others.

If you're not a pSA, you don't need to do anything.

Will users be notified of the results of the review?

Users will only be notified if their renewal is denied. They'll be sent an email and given instructions for how to submit a new request for access, in case they feel they've been incorrectly denied.

What if my group/facility doesn't have a pSA?

If your entity doesn't yet have a pSA, please see our provider manual for a guide to assigning one. **Soon, all provider groups and facilities will be required to have a pSA assigned or they will lose prism access**. Keep an eye on our news updates for more. We'll communicate in advance before this mandate goes into effect.

Don't know if you have a pSA assigned?

1. Go to your prism profile and find your list of affiliations.
2. Scroll to the far right of the table and select "Show pSA details." If you don't have this option, a pSA hasn't been assigned to this affiliation. 2. Scroll to the far right of the table and select "Show pSA details." If you don't have this option, a pSA hasn't been assigned to this affiliation.
3. You can contact the pSA assigned to each affiliation to confirm your access will be renewed, but it's not required.

Questions?

Visit the prism resources page in our provider manual, where there are guides, FAQs and help line numbers listed.

Reminder: Unique NPI required for rehab groups to credential BH providers

We're reminding all rehabilitation groups credentialed with us that, if they'd like to also provide behavioral health (BH) services, they'll need to obtain a unique NPI specific to their BH services.

This will allow us to ensure they maintain the appropriate billing setup for both their rehab and behavioral health services.

What do providers need to do?

If a rehab group would like to provide BH services to our members, they'll need to submit a new enrollment request in prism for BH providers, providing a unique group NPI.

See the note under *Behavioral health facilities* on our Provider Manual's Credentialing criteria by organization type page for details on completing an organizational enrollment application, if appropriate.

BILLING AND PAYMENT

Coding policies going into effect September 23

In alignment with industry standards, we've posted the following policies to our Provider Manual, to go into effect on Sept. 23, 2024.

Below are links and a high-level overview of each policy. Please see each policy for specific billing, coding and reimbursement details.

Policy & link	Notes
Care management services policy	We're clarifying existing criteria and establishing more specific criteria, including aligning documentation requirements with CMS.
Distinct unbundling modifier policy	In alignment with CMS National Correct Coding Initiative (NCCI) standards, we'll no longer allow separate and distinct modifiers (59, XE, XS, XP and XU) to automatically override our clinical edits for unbundling for the codes listed in the policy. The claim lines will deny, and the

Policy & link	Notes
	provider will have the option to appeal with medical records to support the modifier use and payment.
Drug testing policy	We're defining limits on the number of drug tests (definitive and presumptive tests) that can be billed / reimbursed, including moving from a yearly limit of 12 tests (combined definitive and presumptive) to a daily limit of 1 test per date of service.
Radiation oncology coding policy	We're sharing our expectations for radiation oncology billing, which are in alignment with industry standards, including CMS and National Imaging Associates (NIA).

PLANS AND BENEFITS

Do your Medicare patients qualify for Extra Help?

The Centers for Medicare & Medicaid Services (CMS) offers assistance to Medicare members for prescription drug coverage known as the Low-Income Subsidy (LIS) or Extra Help. Many members who qualify for LIS routinely don't apply and receive it. You can help your Medicare patients afford the care they need by raising awareness of this program.

What exactly is LIS?

LIS, also known as Extra Help, is a Medicare program designed to help people with limited income and resources cover health costs, including prescription drugs. LIS was expanded as part of the Inflation Reduction Act in 2022. Medicare members who qualify can receive benefits up to and including:

- $0 Medicare drug plan premium
- $0 health plan deductible
- Paying no more than $4.50 for each generic drug
- Paying no more than $11.20 for each brand-name drug
- Paying $0 for each covered drug once total drug costs (including certain payments made on the member's behalf, like through LIS) reach $8,000

Who qualifies?

There are two scenarios for Medicare members to qualify for LIS:

Members automatically qualify if they...	Members should apply if they...
• Have full Medicaid coverage • Get help from a state for paying Part B premiums (from a Medicare Savings Program) • Receive Supplemental Security Income (SSI) benefits from Social Security	• Are at or below the $22,590 income limit and the $17,220 resource limit for an individual* • Are at or below the $30,660 income limit and the $34,360 resource limit for a married couple*

*Note that these specific qualifications are for 2024 and may change in 2025 and beyond.

Members who qualify receive a one-time letter informing them of their benefits. They will receive letters in subsequent years only if they no longer qualify for LIS, if their LIS benefits change or if they move to a different plan.

What's the impact on you?

LIS helps members get the care they need through financial support. If you're a care manager, you especially will benefit from using it as a tool. By removing cost barriers for prescription drugs specifically, LIS can support increased medication adherence, which will in turn increase your PCP Incentive Program (PIP) rewards.

What can you do?

Care managers and other providers can help Medicare patients determine if they may qualify and apply for LIS benefits. More information and the link to the application can be found at medicare.gov/basics/costs/help/drug-costs.

Note that, to apply, members may need the following documents:

- Social Security card
- Bank account statements, including checking, savings and certificates of deposit
- Individual Retirement Accounts (IRA), stocks, bonds, savings bonds (including book entry securities), mutual funds and other investment statements
- Tax returns

- Payroll slips
- The member's most recent Social Security benefits award letters or statements for Railroad Retirement benefits, Veterans benefits, pensions and annuities

Telephonic outreach may be most effective, so that the member can access these documents at home as you help them through the application process.

What about members who fear the stigma of low-income subsidies?

Some members will be hesitant to apply because of the stigma associated with receiving government assistance. Here are a few talking points to share with members with these concerns:

- The cost of health care, and prescription drug costs in particular, are increasing quickly, making it harder for average Americans to afford the medicine they need
- LIS, or Extra Help, is simply a small add-on to the Medicare plan they're already enrolled in; it is not an entirely separate program
- Part of the goal of expanding LIS through the Inflation Reduction Act was to bring these benefits to a larger portion of seniors—not just those at the lowest income levels
- Once the member qualifies, LIS benefits apply directly to the member's plan, so there's no need for a member to "announce" they have LIS when, say, picking up their prescriptions
- Simply using the name Extra Help instead of Low-Income Subsidy may make the program more appealing to more members

TRAINING OPPORTUNITIES

Register now to learn about our Q4 Medicare/Medicaid Quality campaigns on August 29

Join us for a webinar to learn more about our Q4 Medicare/Medicaid Quality campaigns, including our Q4 areas of focus and member outreach initiatives.

This session will cover topics like:

- Closing patient care gaps through at-home screenings
- Medicare/Medicaid member outreach
- Medicare/Medicaid member and provider incentives

- Increasing patient immunization rates with the VFC program
- Health Outcomes Survey

How to register

You and your providers can join us by registering online.

Can't join us?

All webinars are recorded and posted to our website within a week of the webinar, so you can watch at your convenience.

Questions? Connect with your Provider Strategy & Solutions Consultant, Brandi Stickley.

Access an archive of our PriorityActions for providers emails here.

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