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Halifax Physician Hospital Organization

QUARTERLY PROVIDER NEWSLETTER
FALL 2017

ADDRESSING THE NEEDS OF OUR PROVIDERS AND BUILDING THE FOUNDATION FOR MORE AFFORDABLE AND ACCESSIBLE HEALTH CARE OPTIONS

UPCOMING MEETINGS

HALIFAX PHO BOARD OF DIRECTORS

October 25, 2017 @ 12:00pm Sentara Halifax Regional Hospital, Edmunds Room

We Need Your Email

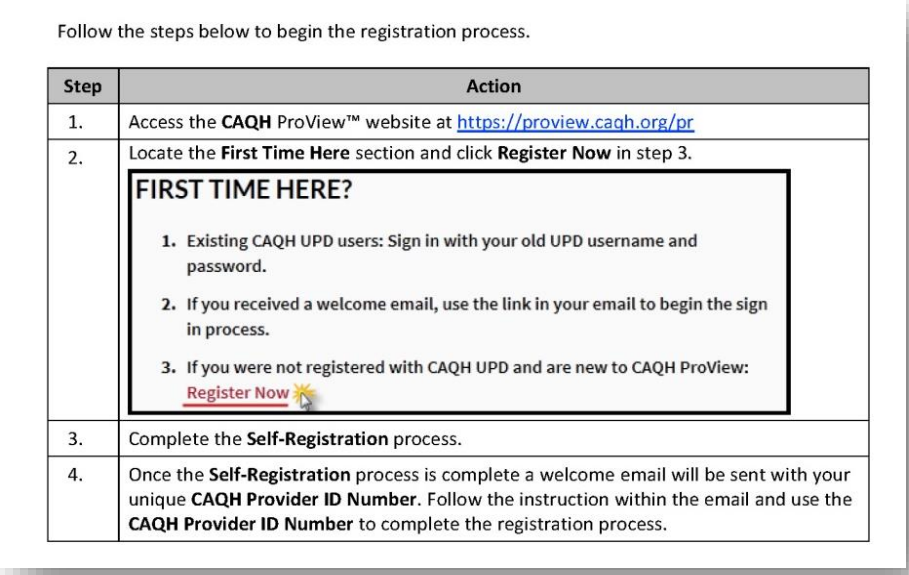
As more and more of our communications occur electronically, we want to be sure we have the most up-to-date email address for you and your practice. Please inform Catina Evans, **cevans@gatewayhealth.com** or Niki Prignano, **nprignano@gatewayhealth.com of** any changes or updates to your email address.

YOUR GATEWAY HEALTH PROVIDER OPERATIONS TEAM		
Name	**Email Address**	**Phone 434-799-3838**
John Holshouser	jholshouser@gatewayhealth.com	Extension 3017
Tiffany Stolzenthaler	tstolzenthaler@gatewayhealth.com	Extension 3003
Catina Evans	cevans@gatewayhealth.com	Extension 3053
Niki Prignano	nprignano@gatewayhealth.com	Extension 3062

Initial or Re-Credentialing Time?

Want to speed up your application?

Visit https://proview.caqh.org



Follow the steps below to begin the registration process.

Step	Action
1.	Access the **CAQH** ProView™ website at https://proview.caqh.org/pr
2.	Locate the **First Time Here** section and click **Register Now** in step 3.
3.	Complete the **Self-Registration** process.
4.	Once the **Self-Registration** process is complete a welcome email will be sent with your unique **CAQH Provider ID Number**. Follow the instruction within the email and use the **CAQH Provider ID Number** to complete the registration process.

FIRST TIME HERE?

1. Existing CAQH UPD users: Sign in with your old UPD username and password.
2. If you received a welcome email, use the link in your email to begin the sign in process.
3. If you were not registered with CAQH UPD and are new to CAQH ProView: Register Now

Insurance, Plan, or Benefit Changes

Please remember that insurance plans and benefits can change from year to year. Please check insurance cards for new co-pays, deductibles and other insurance information. If you have questions regarding the plans that you participate in, please do not hesitate to contact Catina Evans at **cevans@gatewayhealth.com**.

OptimaHealth

REMINDER: ALL PROVIDERS PLEASE SIGN-UP FOR PROVIDER CONNECTION ON OPTIMAHEALTH.COM

Ability to:

Check Claim status • Claim Reconsideration

View Eligibility• Create OB Auths

Access Provider Manual • Access In-Office Lab List

Questions, contact:

Sheryl D. Motley, Network Educator Optima Health Plans

(p) 336-949-9108 ◊ (f) 336-949-9303

Gateway Health

In order to keep our records accurate, we request that any changes to the practice be sent to Gateway. Please provide the information below so we can insure accurate representation of your practice in our directory and with our payor partners.

Have there been any changes in your provider roster in the last 6 months?
Yes _____ No _____

If yes, please list any changes (i.e., new provider added, provider termed) below:

_____

_____

_____

Have there been any changes to your practice information in the last 6 months?

Yes _____ No _____

If yes, please provide any changes below:

Practice Name: _____

Address: _____

Telephone: _____

Fax: _____

Email: _____

Office Manager's Name: _____

Accepting New Patients? Yes _____ No _____

Please return to:
Credentialing Department
Fax: 434-799-3837

12 Little-Known Facts About MIPS

By *MSOC Health*
April 14, 2017

Most practices that don't successfully report 2017 data for Medicare's new Merit-Based Incentive Payment System (MIPS) will face a 4% reduction in Medicare payments in 2019. On the other hand, you could potentially receive an increase in your payment rate by optimizing your MIPS score. CMS offers extensive education about the program at www.qpp.cms.gov.

We'll go beyond the basics to answer some FAQs and share some of the little-known facts that might surprise you.

Q: What's the minimum I have to do to avoid the 4% reduction?

A: You need a MIPS score of 3 (out of 100 points). To get 3 points, you can do any of the following:

- Report 1 quality measure to CMS on 1 Medicare patient
- Attest to 1 improvement activity performed consistently during any 90 days in 2017
- Attest to the 4 measures that make up the Base Score of the Advancing Care Information (ACI) category – these are from the Modified Stage 2 Meaningful Use measures and you must meet the threshold of 1 patient or answer Yes for each measure during any 90 days

Q: Why would I worry about doing anything more than the minimum?

A: There are three important reasons.

- First, MIPS will get more difficult in future years with a 12-month reporting period and a likely threshold of 50-60 instead of 3 – this is the year to get your processes in place.
- Secondly, a score of 70 or higher will give you a significantly higher increase in 2019 payments because you will share in a $500 million additional incentive fund.
- Finally, the MIPS score will be published at www.medicare.gov/physiciancompare and will be marketed by Medicare, AARP, Consumer Reports and your competitors as the gold standard in evaluating the value of different physicians and practices.

Q: If I don't have an Electronic Health Records system, does MIPS apply to me?

A: Yes, however without a 2014 Certified EHR, you will be unable to earn any points in the Advancing Care Information (ACI) category so your maximum possible score will be 75 instead of 100 points. You can still earn points in the Quality and Improvement Activities Categories. Please note that if you have never participated in the Meaningful Use program, there is a special one-time exception to the 2016 Meaningful Use program that can eliminate the scheduled 3% reduction in 2018 payments.

Q: Do I get a higher score if I report data for 12 months instead of just 90 days?

A: Not necessarily. You can report for any period of time between 90 days and 12 months; your score is based on the data you report. Choose the reporting period that maximizes your score.

Q: Do I have to use the same 90-day reporting period for each category?

A: No. You can select a different reporting period for each of the 3 categories: Quality, Advancing Care Information (ACI-similar to MU) and Improvement Activities.

Q: What should I consider in choosing whether to report as a Group or as Individual Clinicians?

A: Most importantly, unless you plan to use the GPRO website to report quality measures, you'll make the decision at the time you report – in early 2018. Here are factors to consider:

- Which approach provides the highest MIPS score and the greatest revenue impact? When reporting as a Group, each provider in the group will have the same score and the same payment adjustment. When reporting as Individual Clinicians, each provider will have a different score and be paid at a different payment rate in 2019.
- Are some providers excluded due to Low Volume? If so, they are not required to report as Individual Clinicians but would be included as a member of the Group.
- In a multi-specialty group, do some providers have 6 great quality measures to report on while another specialty struggles to find 6 measures that make sense for them? In this situation, Group reporting may be beneficial as you can select measures that apply only to one specialty within your practice.

Q: What happens if I move to a new practice by the payment year (2019)?

A: Your MIPS score will move with you. If your practice reports as a Group in 2017, each clinician in the group receives the same MIPS score. In your new practice, your 2019 payment rate will be based on the MIPS score you earned in 2017 regardless of which practice you

were in. If you had 2 MIPS scores in 2017 because you worked in 2 different practices that year, your 2019 payment under a new TIN will be based on the higher of the two scores.

Q: I only see patients in the hospital, am I excluded from MIPS?

A: Probably not. There are only three exclusions from MIPS:

- Low Volume Exclusion: Less than $30,000 in Medicare Allowables OR less than 100 Medicare patients during a 12 month period.
- New Medicare Provider Exclusion: 2017 is the first year that the provider billed to Medicare under their NPI number.
- Advanced Alternative Payment Model: Provider is deemed a participating provider in a Medicare Advanced APM (see next question).

However, Hospital-based providers are excluded from the ACI (MU) category. The 25% weight typically assigned to this category is reassigned to the Quality Category making Quality worth 85% of the Final MIPS Score and Improvement Activities worth 15%. Note that the definition of Hospital-based has changed to more than 75% of encounters in POS 21, 22, or 23 (Inpatient, Hospital Outpatient, ED).

Q: I am participating in a Medicare ACO. Do I have to report MIPS?

A: It depends on the specific Medicare Alternative Payment Model (APM) you are participating with. Some programs have been deemed "Advanced APMs" and others are deemed "MIPS APMs." You'll want to carefully review the information on www.qpp.cms.gov in order to determine which you are participating with and the specific rules that apply to you.

Q: What should I consider in selecting the Quality Measures to report?

A: Probably one of the most difficult issues in implementing MIPS. Be sure to consider the following:

- How will you collect the necessary data and report it to CMS? There are over 250 measures and 5 reporting options – claims, certified EHR, registry, qualified clinical data registry (QCDR), and GPRO Website. Some measures are only available for some reporting options.
- There are different benchmarks for different reporting options. Be sure you are using the correct benchmarks to determine your score. The same measure may have lower benchmarks if you report it via registry as compared to EHR or vice-versa.
- Measures with less than 20 eligible cases, or those with no benchmarks will receive a score of 3.
- Some measures are listed as 'Topped Out' meaning that the national average is > 95%. It is ok to report these for 2017 however they may not be available in 2018 and beyond.

Q: I am switching to a new EMR in 2017. Under the Meaningful Use program, I would have received a Hardship Exemption for 2019. Does the same exemption apply under MIPS?

A: You are not exempted from MIPS altogether, but you may apply for a Hardship Exemption for the Advancing Care Information (ACI) Category. Applications will be available in early 2018 and if approved, your Quality Category would be reweighted to be 85% of your Final MIPS Score with 15% assigned to the Improvement Activities Category.

Q: How are the Improvement Activities reported to CMS and what type of documentation is required?

A: Improvement Activities can be reported to CMS via an attestation website that will be available in early 2018. You will simply attest that you performed the activity consistently during the 90-day reporting period you have chosen. If you are reporting as a Group, only one provider in the group must perform the activity. CMS has declined to provide further guidance about the requirements of each activity. You will need to retain appropriate documentation to justify and support your attestation in the event of an audit.

Business Advisors for the Healthcare Industry

Mandatory Notice!
Due by December 31, 2017
The 2017 IT Security Risk Assessments – MIPS, MU, HIPAA Compliance

In our current healthcare environment, cyber-attacks are becoming more powerful and debilitating, IT security risk assessments are a pivotal process to help identify and minimize potential security incidents or, worse, a security breach.

Security Risk Assessment must be completed in 2017 as MIPS, Meaningful Use (MU), and HIPPAA Compliance are due at the end of this year. There is no time to wait with only 2.5 months before this quickly approaching deadline.

There are many methods on how to conduct a risk and threat assessment. Overall, a full IT security risk assessment should illustrate the following components:

- What needs to be protected?
- Who/What are the threats and vulnerabilities?
- What are the implications if they were damaged or lost?
- What is the opportunity cost to remediate the security risk or leave the exposure?
- What can be done to minimize exposure to loss or damage?

The core areas in a healthcare IT security risk assessment include scope, data collection, analysis of policies and procedures, threat analysis/scans, vulnerability analysis/scans, and evaluation of risk acceptability. Once the IT security risk assessment is completed, the final document should be a "living" document, where it is reviewed and updated on a regular basis.

For more information on IT Security we invite you to join us for a conversation about the top most infamous Security Breaches from 2017 and why they matter to the Medical Industry, in our October Coffee with Coker webinar . During this webinar we will focus on best practices for how to mitigate risk from these new threats. We will also explore the updated OCR regulations and notifications and how they can impact your medical specialty. We hope you will be able to join us for this webinar on **October 19, 2017, at 2:00pm-3:00pm EDT.**

To register for the webinar, visit:
https://register.gotowebinar.com/register/1520103793419590401

Gateway Health is pleased to announce our partnership with the Medical Society of Virginia Insurance Agency (MSVIA). We've selected to partner with MSVIA based on its reputation for providing outstanding service and a full range of insurance coverage options.

MSV℠
MEDICAL SOCIETY OF VIRGINIA

MSVIA understands you

MSVIA was created by physicians for physicians. The agency's board of directors is comprised of physicians, practice managers and insurance professionals who have experience with and knowledge of the real challenges you face.

What that means for you

As a wholly owned subsidiary of the Medical Society of Virginia (MSV), MSVIA's revenues benefit Virginia's physicians by supporting legislative advocacy, practice management guidance and other initiatives.

What you can expect

- **Experience:** MSVIA celebrates more than 15 years of serving the physician community, with a professional staff possessing more than 300 years of combined insurance experience.
- **Quality**: MSVIA offers access to top national providers of health, life, disability, dental, professional liability and other property and casualty coverage.
- **Focus**: MSVIA focuses on advising physicians and their practices with a commitment to finding the highest quality coverage for the best value.

No-obligation quote

Gateway Health encourages you to contact MSVIA for a no-obligation consultation. If you have questions or wish to obtain a quote, please contact MSVIA toll-free at 877 | 226-9357 or use the online quoting tool at www.msvia.org.

MSVIA is happy to assist.

See the following MSVIA flyer for more information!

Who better to help you?

MSVIA 15 YEAR ANNIVERSARY

Each day thousands of physicians treat their patients with confidence in knowing that MSVIA is their insurance partner. Building on the Medical Society of Virginia's legacy of caring about Virginia physicians, our team stands ready to support you with unbiased guidance and exceptional service.

Request a quote at www.msvia.org/RequestQuote.

MEDICAL SOCIETY OF VIRGINIA INSURANCE AGENCY

MSV℠

VIRGINIA PREMIER ELITE PLUS
a Commonwealth Coordinated Care Plus Program

Provider Notification

Summary:

To ensure that you are paid accurately and timely, we want to take this opportunity to notify you of the ways in which you can submit claims to our new CCC Plus plan.

Claims Submission

Electronic Claim Submission:

Clearinghouse	Contact Information	Virginia Premier Elite Plus Payer ID
Availity	800-282-4548 www.Availity.com	All Claim Types: VPEP1
McKesson (Relay Health)	800-981-8601 www.mckesson.com	837 Professional: 1244 837 Institutional: 4573

Paper Claim Submission:

Mail to:
Virginia Premier Elite Plus
P.O. Box 4369
Richmond, VA 23220

Virginia Premier Claims Portal

CMS 1500 claims can be submitted on our website: www.vapremier.com

What this means to you:

All CCC Plus claims should be submitted though one of these channels to ensure proper and timely payment from Virginia Premier Elite Plus for all CCC Plus members. Failure to submit Virginia Premier Elite Plus claims through one of the channels above will result in a denial from Virginia Premier.

<PROV_0917-CSB-400045>

VIRGINIA PREMIER ELITE PLUS
a Commonwealth Coordinated Care Plus Program

When does this change become effective?

August 1, 2017

If you have any questions, please contact Provider Services. We are available Monday through Friday from 8:00 a.m. to 5:00 p.m. at 804-819-5151 or Toll-free 800-727-7536.

<PROV_0917-CSB-400045>

Provider Notification

New Virginia Premier Elite Plus Fax Number

Summary:

Virginia Premier Elite Plus (Virginia Premier) has implemented a new fax number exclusively for outpatient service authorization requests. The new fax number for OUTPATIENT SERVICES and SUPPORTING CLINICALS is:

<1-877-739-1371>.

Purpose:

Our goal is to provide high quality and rapid service to you! This dedicated fax number for outpatient service authorization requests will help us deliver this level of service to you.

What this means to you:

Providers should begin faxing outpatient service authorization requests to this number: <1-877-739-1371> immediately. If you have any questions about the prior authorization process, please call <1-888-251-3063>. Additionally, see listing below of all toll-free phone and fax numbers for services.

SERVICE	CONTACT
LTSS Requests Requests will be addressed within 5 business days; expedited requests no later than 72 hours	**Fax:** <1-877-794-7954> Or contact our Care Coordination Team: <1-877-719-7358; press option 3-3-2-1>
Outpatient Service Requests (excluding LTSS) Requests will be addressed within 3 business days; expedited requests no later than 72 hours	**Fax:** <1-877-739-1371> Referrals and Authorizations Dedicated Line: <1-888-251-3063, press option 4> You can also submit requests via our Provider Portal located on our website: <www.vapremier.com>
Medical Admission Requests Admission authorizations will be addressed within 1 business day	**Fax:** <1-877-739-1365> Referrals and Authorizations Dedicated Line: <1-888-251-3063, press option 4>
Mental Health and ARTS Requests Services authorized by Beacon Health Options	**Fax:** <1-888-237-3997> **Call:** <1-844-513-4951>
Non-Traditional Behavioral Health Requests Services authorized by Magellan through 12/31/17	**Fax:** <1-888-656-5712> **Call:** <1-800-424-4971>

Thank you for continuing to provide quality care to our members.