INSIDE THIS ISSUE:

- *MEETINGS* ***1***
- *PROVIDER OPERATIONS* ***1***
- *MIPS UPDATE* ***3***
- *MULTIPLAN* ***7***
- *MSVIA* ***9***
- *FAMIS UPDATE* ***11***

QUARTERLY PROVIDER NEWSLETTER
SPRING 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

July 26, 2017 @ 12:00pm Sentara Halifax Regional Hospital, Edmunds Room

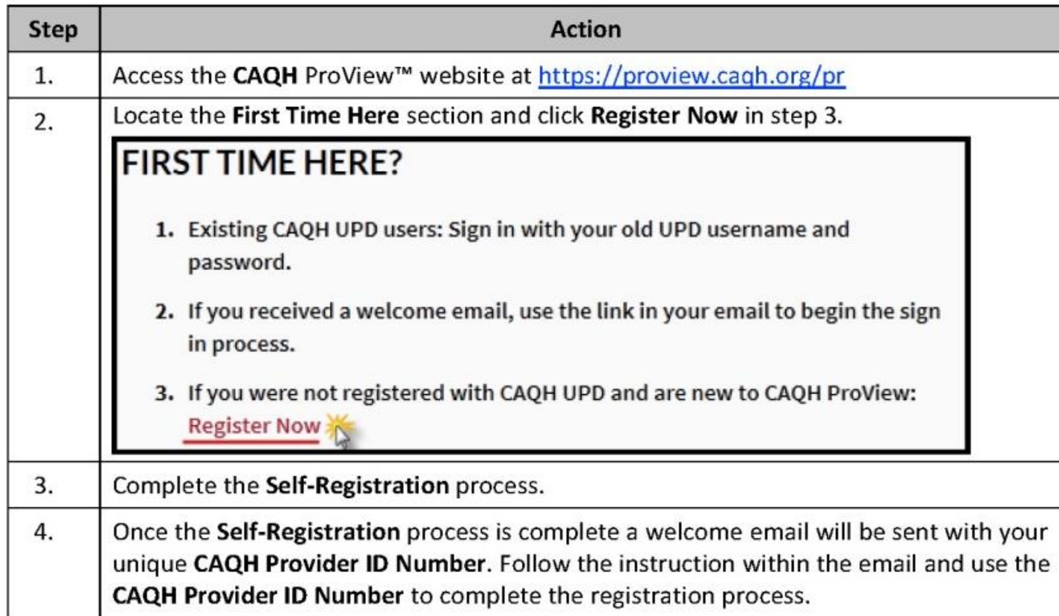
We Need Your Email

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. 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
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.

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

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.**

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.

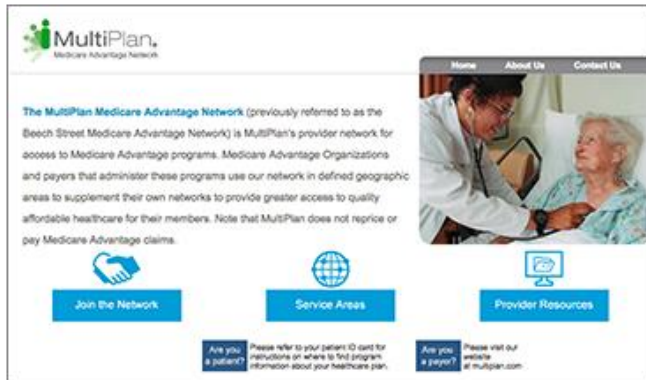
Q: I am switching to a new EMR in 2017. Under the Meaningful Use program, I would have received a Hardship Exemption for 2019. Does the same exemption apply under MIPS?

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.

Notices for Providers Participating in Medicare Advantage Programs



CMS requires our clients that are Medicare Advantage Sponsors to maintain information regarding network adequacy and availability. To support this requirement, MultiPlan asks all providers participating in our Medicare Advantage Network to inform us of any changes to your provider directory information (e.g., street address, phone number, office hours) and whether you are accepting new patients. Please promptly inform MultiPlan of any changes to this information.

MultiPlan Welcomes MedRisk for Workers' Compensation

MultiPlan is pleased to announce a new relationship with MedRisk, a network that is utilized by the top workers' compensation clients in the industry.

MedRisk is a national network of physical therapists, occupational therapists, chiropractors, EMG specialists and radiologists that specialize in the treatment of work-related injuries. MedRisk's clients include top national workers' compensation insurers, third-party administrators, state funds and Fortune 500 employers.

Providers participating in the MultiPlan Workers' Compensation Network may be marketed directly to MedRisk's clients through multiple channels, such as:

- Directory listings and online search engines
- Tradeshows, special events and vendor fairs
- Recommendations to adjusters, nurse case managers and physicians by MedRisk account managers

If you have questions about the MedRisk access, processes or procedures please contact MedRisk's dedicated Network Team at 866-697-3707.

2016 CMS Compliance Training Requirement

The Centers for Medicare & Medicaid Services (CMS) and MultiPlan network provider agreements for participation in the Medicare Advantage Network mandate that all those contracted to provide healthcare services to Medicare Advantage beneficiaries complete the requisite General Compliance and Fraud, Waste and Abuse (FWA) training within 90 days of the contracting and annually thereafter. As of January 1, 2016, CMS requires all downstream entities, such as providers participating in MultiPlan's Medicare Advantage Network and their employees and subcontractors, to complete the CMS developed web-based compliance training available on the Medicare Learning Network (MLN). Providers participating in the Medicare program are deemed to have met the CMS compliance training requirement for FWA. However, these Providers are still required to complete the CMS standardized General Compliance training.

Providers participating in MultiPlan's Medicare Advantage Network have the following three options to ensure they have satisfied the General Compliance <u>and</u> FWA training requirements:

- Complete the General Compliance and/or FWA training modules located on the CMS MLN. Once an individual completes each of the trainings, the MLN system will generate a certificate of completion. The MLN certificates of completion will be accepted by MultiPlan as proof of satisfying the training requirement;
- Download and incorporate the content of the CMS standardized training modules from the CMS website into their organizations' existing compliance training materials/systems; or
- Incorporate the content of the CMS training modules into written documents for providers (e.g. provider guides, participation manuals, business associate agreements, etc.).

Although the training content cannot be modified, CMS will allow modifications to the appearance of the content (i.e. font, color, background, format, etc.). Additionally, providers may enhance or wrap around the CMS training content by adding topics specific to their organization or the employee's job function. At MultiPlan's request, providers must submit an attestation confirming that they have completed the appropriate General Compliance <u>and</u> FWA training.

Providers participating in MultiPlan's Medicare Advantage Network are required to maintain evidence of completion of the General Compliance <u>and</u> FWA trainings, such as training materials, training logs and program materials, for a period of ten (10) years and must make such evidence available to MultiPlan for review upon request.

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.

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.

Who better to help you?

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

Update: Policy Change Produces Good Results!

A new DMAS policy that went into effect in October was designed to keep newborns from losing FAMIS coverage on their first birthday via auto-cancellation. It is working well.

As of December, **3,700 one-year-olds have retained coverage** due to this policy change. Families of these one-year-olds will **still need to complete a renewal application** for coverage to continue.

Good News for Non-Resident Kids and Pregnant Women!

It is now easier for lawfully-residing children and pregnant women to qualify for the FAMIS programs! Effective September 2016, individuals who hold non-immigrant visas are considered U.S. "residents" when applying for Medicaid or the FAMIS programs. These "residents" will **no longer have to sign a statement attesting to their intent to remain** in the Commonwealth of Virginia beyond their visa.

Additionally, individuals admitted to the U.S. on non-immigrant visas *(and individuals who do not intend to work in the U.S.)* are **no longer required to apply for a Social Security Number *(SSN)*** to receive coverage through the FAMIS programs.

New Expertise at VHCF

The Virginia Health Care Foundation welcomes Emily Roller as its new Child Health Insurance Program Manager. Prior to joining the VHCF Child Health team, Emily provided training and technical assistance to Virginia's Federally Qualified Health Center *(FQHC)* Certified Application Counselors *(CACs)* at the Virginia Community Healthcare Association. Before that, Emily served as an outreach worker for the Virginia Health & Wellness Passport program. Emily will be the new voice on the end of the *SignUpNow* hotline, 804-828-6062, and at SUN workshops. She can also be reached at emily@vhcf.org.

A Fresh, New Look for Virginia's Managed Care Website

Do you need to assist your clients with information about Medicaid Managed Care? Virginia's online resource center for Managed Care Organizations *(MCOs)* has a new look! Head to the Virginia Medicaid Managed Care website to figure out which MCOs serve your locality or region, and to find your service area's annual Open Enrollment Period. You can

check out the redesigned Virginia Medicaid Managed Care website: https://virginiamanagedcare.com/learn/open-enrollment.

Smiles For Children Can Help Prevent Serious Health Risks

Children who do not visit the dentist are at risk for long-lasting health consequences. Tooth decay is one of the most common preventable diseases seen in children. **Children as young as 12-18 months can get cavities, causing pain.** This may prevent them from eating, speaking, sleeping, and learning properly.

The truth is that nearly all dental disease is preventable. However, too often children do not get necessary preventive care - things like cleanings, X-rays, and fluoride. This not only leaves them at risk for serious dental disease, but it can also impact their overall health. Research has linked dental disease to diabetes, asthma, and other chronic conditions.

The great news is that the 835,000 **children who are enrolled in Virginia's FAMIS programs have dental coverage through the *Smiles For Children* program.** In state fiscal year 2016, 430,000 of them went to the dentist.

Smiles For Children provides comprehensive dental benefits to members under 21 years of age, limited benefits to adults ages 21 and up, and medically appropriate dental benefits to pregnant members over age 20. The ***Smiles For Children*** program gives coverage for the care they need. It includes:

- Regular dental checkups *(every six months)*
- X-rays *(when necessary)*
- Cleaning and fluoride *(every six months)*
- Sealants
- Information and education about oral care
- Space maintainers
- Braces *(if necessary)*
- Anesthesia
- Extractions
- Root canal treatment
- Crowns

If you work with children in the FAMIS programs, you can help them use the ***Smiles For Children*** dental program and possibly avoid serious dental disease.

Help children get started with dental care.

The first step is to get them an appointment with a dentist. Finding a dentist who accepts ***Smiles For Children*** is easy - members can call a toll-free number or use the ***Smiles for Children*** website.

- **Option 1:** Call 1-888-912-3456. The call center is available 8am-6pm Monday-Friday, and can even help the member make an appointment!
- **Option 2:** Visit the website at www.DentaQuest.com.

When they call to make an appointment, members should be sure to tell the dental office that this child is a ***Smiles For Children*** member. Remind them that on the day of the appointment, they should be sure to bring their child's Medicaid card (either the blue and white card, or their MCO ID card).

Questions? Need Help?
If you have questions about the ***Smiles For Children*** program, please contact **Jackie Wake, State Outreach Coordinator**, at Jacqueline.Wake@DentaQuest.com. She can also provide you with a list of dentists in your area who accept ***Smiles For Children*** members.

Application for Health Coverage to Get One Step Shorter

The paper Application for Health Coverage & Help Paying Costs *(streamlined, federal application for Medicaid, FAMIS, and coverage through the Marketplace)* will be one step simpler beginning in 2017.

Step 7, entitled "Consent to Share User Profile Information," will disappear. State agencies are now allowed to share clients' information using the Virginia Information Technologies Agency's *(VITA's)* Enterprise Data Management *(EDM)* system, which includes the Department of Motor Vehicles and other state agencies, without this additional permission.

This is another step the Commonwealth is taking to make applying for the FAMIS programs easier for families.