Latest updates on Group Health joining Kaiser Permanente

**GROUP HEALTH SIGNED AN AGREEMENT** to be acquired by Kaiser Permanente—a nationally recognized, nonprofit health care leader, and one that shares our values and commitment to putting members’ health first. The acquisition is pending approval from state regulators. If approved and the transaction is completed, Group Health will become a part of Kaiser Permanente. Joining Kaiser Permanente helps ensure that our approach to care and coverage can thrive in the future.

**Fast Facts for Providers**

**What does the acquisition mean for providers?** Here’s a quick summary of what you should know today. If the acquisition is completed:

- Except for planned changes to the Group Health name, your existing provider contract won’t change because of the acquisition.
- You will continue to receive support from our Provider Assistance Unit and your local Provider Services team.
- The processes for submitting claims and requesting prior authorization won’t change.
- 2017 existing member plans won’t change.

*continued on page 2*

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**CLINICAL NEWS**

- Chronic Opioid Therapy Safety Guideline updated
- Hepatitis C Screening Guideline updated

**PHARMACY NEWS**

- Site of Service Prior Authorization
- Group Health Drug Formularies
- OptumRx is new claims processor for all Medicare Part D drugs

**CONTINUING MEDICAL EDUCATION**

**PROVIDER UPDATE**

is published quarterly for Group Health contracted providers.

Send story ideas and comments to providercommunications@ghc.org.
Electronic funds transfer is Group Health’s standard payment method

In 2017, Group Health will begin sending Claim Payment Cards in lieu of paper check payments. If you have not enrolled for EFT payment through U.S. Bank Payment Accelerator yet, please do so now.

**THERE ARE MANY BENEFITS TO REGISTERING:**

- Group Health payments directly deposited into your bank account
- Email notifications of payments
- 24/7 access to the Payment Accelerator provider portal
- Optional 835 file transmission direct to you or your clearinghouse
- ERA/EFT from multiple payers

Visit our [EFT page](#) on the provider site for more information. If you need help enrolling, please contact the Payment Accelerator Implementations Team toll-free at 877-855-7160 or by e-mail at [connect@instamed.com](mailto:connect@instamed.com).

For other questions, please contact your Provider Services consultant.

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**2017 CALENDAR**

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**GROUP HEALTH HOLIDAYS**

**NEW YEAR’S DAY**
Monday, January 2, 2017

**MARTIN LUTHER KING, JR. BIRTHDAY**
Monday, January 16, 2017

**PRESIDENTS’ DAY**
Monday, February 20, 2017

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**PROVIDER NEWS**

**continued from page 1**

Latest updates on Group Health joining Kaiser Permanente

**Fast Facts for Members**

**What does the acquisition mean for members?** If a member asks you what it means for them, here’s a quick summary of what you can tell them.

If the acquisition is completed:

- The Group Health plan they select for 2017 won’t change.
- They will have access to the same hospitals they go to today.
- Medicare members will still have access to the SilverSneakers® fitness program.

**How to Stay Informed**

Learn more about the proposed acquisition at [ghc.org](http://ghc.org). Find out the status of the acquisition, read the latest Q&A, see fast facts, and more. While we may not have all the answers today, we will update you when there is new information to share.
Performance Improvement Spotlight: Sustaining the Improvement

This is the fourth article in a quarterly series on quality performance improvement intended for new Operations and Quality leaders. Topics covered in this series include:

- Overview of Performance Improvement Principles (March 2016)
- Defining the Opportunity (June 2016)
- Engaging the Team (September 2016)
- Sustaining the Improvement (December 2016)

As most managers know, implementing a change is very different than sustaining a change. Implementing a change involves identifying and quantifying the opportunity and then engaging front-line leaders and staff to adopt a new process. In order to sustain a performance improvement initiative a manager must also monitor the ripple-effect, address short-cuts, and manage gaps in awareness, alignment, and accountability.

Step 1: Monitor the Ripple-Effect

After implementing a new performance improvement initiative it is vital to monitor the impact that change has on related workflows and teams. There can be an unexpected “ripple-effect” when one team adopts a new process without anticipating the impact it might have on another team.

An example of this ripple occurred in one practice that increased their capacity in the reception team to do additional outreach and scheduling for Breast Cancer screenings. This had an unexpected ripple-effect for their radiology team who struggled to schedule the unexpected demand. The end result was a frustrating experience for many patients who were unable to promptly schedule their exams, and for many staff who were unable to coordinate with their peers to meet the needs of the patient.

To monitor the ripple effect, teams and leaders should huddle regularly to review changes in performance metrics and related workflows.

Step 2: Address Short-Cuts

When team members encounter a choice between being efficient and being compliant, they will commonly choose to be efficient. This saves them time and energy but may cost the clinic in overall quality performance because they are not complying with the established protocol.

For example, one clinic had a policy that staff should schedule colorectal cancer screening exams at the time of the visit and on the patient’s behalf. Several medical assistants diverged from the clinic policy, instead handing out referral cards recommending that patients schedule the screening appointments on their own. This shortcut had a negative impact on the clinic’s HEDIS® performance, because patients were less likely to comply with the recommended screening when the appointments weren’t scheduled for them.

Managing short-cuts can be challenging and requires regular monitoring of the workflow in real-time. Sometimes short-cuts can reveal a best practice process and those opportunities should be

Continued on page 4
Performance Improvement Spotlight: Sustaining the Improvement

explored. All too often, however, short-cuts result in a deviation from a carefully planned initiative and may have a negative impact on the overall strategy.

**STEP 3:**
Manage Gaps in Awareness, Alignment, and Accountability

The keys to quality performance improvement are awareness, alignment, and accountability.

- Do employees know they have a responsibility to meet a measure?
- Do they agree with the objective and workflow?
- Are they able to monitor their current performance?

- Do they have a forum to communicate changes and barriers in their environment that may impact their ability to perform?

Managing gaps in awareness, alignment, and accountability is an ongoing task. Some staff may have gaps because they’re new to the clinic and haven’t learned the protocols or processes. Some managers may overlook the value of regular huddles to review current performance. Some clinics lack the ability to report on key measures which can limit a team’s ability to improve.

To create and sustain a quality performance improvement intervention a practice must identify and define the opportunity, engage their staff in the change process, and monitor and sustain the initiative even after the implementation is complete.

**Questions?**

If you have questions or would like more information about quality performance improvement strategies, please contact Daniel Heindel, MPA, Quality Consultant at heindel.d@ghc.org.

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**CHANGES TO MEDICARE ADVANTAGE PLANS FOR 2017**

Group Health Medicare members in the Northwest service area (Island, San Juan, Skagit and Whatcom counties) who wish to stay with Group Health for 2017 will have 2 plan choices for the new year, the Harbor plan (Medicare Advantage with Part D drug coverage) or the Basic plan (Medicare Advantage with no Part D drug coverage).

The Haven plan, introduced 2 years ago, is being discontinued and all GH Medicare members affected were officially notified by letter in late September. Group Health remains committed to serving Medicare beneficiaries in these counties and we are working hard to provide options that are increasingly competitive in the coming years.

As a provider, your participation in our Medicare Advantage provider network is not affected by these changes.

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**Rehabilitation Authorizations**

**EFFECTIVE JANUARY 1, 2017,** prior authorization will no longer be required for physical therapy, speech therapy, occupational therapy, or massage therapy for most of our non-Medicare members.

Please note that a prescription or order from a physician that includes a written plan of care to restore function is still required. Visits will be allowed up to the benefit limit per the member’s plan. The member must see a provider who is in their network. To determine if a provider is in the network, please refer to the Provider Directory.

Please note that lymphedema therapy, iontophoresis, cardiac rehabilitation, and pulmonary rehabilitation require medical necessity review. If a prior authorization is not requested, medical necessity review will be performed when the claim is received. It is recommended that an authorization be requested prior to the service for these items to avoid an unexpected claim denial.
New CMS Notification Procedures to be implemented in 2017

Notification Procedures for Outpatients Receiving Observation Services

The Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act) requires hospitals and Critical Access Hospitals (CAH) to provide notification to individuals receiving observation services as outpatients for more than 24 hours explaining the status of the individual as an outpatient, not an inpatient, and the implications of such status.

MOON—the Medicare Outpatient Observation Notice

Hospitals and CAHs will be required to furnish a new proposed CMS-developed standardized notice, the Medicare Outpatient Observation Notice (MOON), to a Medicare beneficiary who has been receiving observation services as an outpatient for more than 24 hours. Under the final rule, hospitals and CAHs may deliver the MOON to individuals receiving observation services as an outpatient before such individuals have received more than 24 hours of observation services. The notice must be provided no later than 36 hours after observation services are initiated or, if sooner, upon release;

- The MOON will inform of the reason(s) they are an outpatient receiving observation services and the implications of such status with regard to Medicare cost sharing and coverage for post-hospitalization skilled nursing facility (SNF) services; and

- An oral explanation of the MOON must be provided, ideally in conjunction with the delivery of the notice, and a signature must be obtained from the individual, or a person acting on such individual’s behalf, to acknowledge receipt.

- In cases where such individual or person refuses to sign the MOON, the staff member of the hospital or CAH providing the notice must sign the notice to certify that notification was presented.

An updated version of the Medicare Outpatient Observation Notice which alerts Medicare beneficiaries about the potential coverage consequences of inpatient vs. outpatient status at hospitals, was released by the Centers for Medicare & Medicaid Services early December. Beginning in March, hospitals will be required to notify Medicare beneficiaries of the financial consequences of receiving at least 24 hours of hospital services under outpatient status.

Starting March 6, 2017, hospitals will be required to present the MOON advisory in writing and verbally to Medicare beneficiaries who receive at least 24 hours of hospital services under outpatient status.

OUTPATIENT SURGERY COPAY COMPLIANCE CHANGES

Group Health recently discovered that we are out of compliance regarding gathering sufficient outpatient surgery copay charges.

As part of our corrective action plan to remedy this issue, the outpatient surgery copayment is now deducted from the facility charges. However, there may be times that we adjust claims to deduct additional cost shares from the professional charges, if the member’s outpatient surgery copayment exceeds the allowed amounts on the facility charges. We are adjusting claims with a date of service after 1/1/15. As a result, our members will be accurately charged their full copay amounts according to their contractual agreements.

Regarding professional charges, if you receive an adjustment paying up to allowed charges on a claim that previously applied an outpatient surgery copayment, please refund our member as soon as possible.
Chronic Opioid Therapy Safety Guideline updated

Group Health’s Safety Guideline for Patients on Chronic Opioid Therapy for Chronic Non-Cancer Pain has been reviewed and updated. The guideline is in compliance with the State of Washington regulations WAC 296-919-850–863 on the use of opioids in the treatment of patients with chronic non-cancer pain.

NEW IN THIS UPDATE

• A list of Group Health provider expectations has been added, with the aims of decreasing practice variation, improving patient safety, ensuring compliance with Washington State law, and ultimately increasing both patient and provider satisfaction.

• Continuation of chronic opioid therapy should be considered only when it is associated with clinically meaningful improvement in function (CMIF), defined as an improvement in pain and function of at least 30% as compared to the start of treatment or in response to a dose change.

• The PEG Tool (Pain intensity, interference with Enjoyment of life, and interference with General activity) has replaced the Chronic Pain Scale as the preferred tool for documenting pain and function.

• The definition of high-risk COT dosing has changed from ≥ 120 mg MED to ≥ 90 mg MED, per the 2016 guideline of the Centers for Disease Control and Prevention.

• Every COT patient must have at least one office visit per year dedicated to COT monitoring. Other monitoring visits can be opportunistic and conducted in person, by phone, or by secure message.

• A COT monitoring visit is now required every 3 months for patients in the high-risk monitoring group, instead of every 6 months.

• Prescribing naloxone as a preventive rescue medication for all patients taking ≥ 40 mg MED and their families is now recommended.

• It is now recommended that COT patients be screened for opioid use disorder using the Substance Use Disorder Checklist.

• Principles to prevent conversion from acute to chronic opioid therapy have been added, with links to an external guideline.

For more information about the guideline and its implementation at Group Health, see the new Frequently Asked Questions companion document.

Contacts

Angie Sparks, MD, Medical Director, Clinical Knowledge Development & Support, sparks.a@ghc.org

Avra Cohen, RN, MN, Guideline Coordinator, Clinical Improvement & Prevention, cohen.al@ghc.org
Hepatitis C Screening Guideline updated

Group Health’s Hepatitis C Screening Guideline has been reviewed and updated with new recommendations and processes for referral and follow-up.

SUMMARY OF GUIDELINE RECOMMENDATIONS

- The guideline continues to recommend that patients in the following groups be screened for hepatitis C virus (HCV):
  - People who are at elevated risk for a chronic infection with HCV, such as injection drug users and people with HIV, and
  - People born between 1945 and 1965 (baby boomers, also known as the “high-risk birth cohort”).

NEW IN THIS UPDATE: The guideline no longer recommends “special consideration” before offering HCV screening to patients with conditions such as active alcohol or substance abuse or active psychiatric problems. The screening should be offered to all patients in the groups named above.

NEW IN THIS UPDATE: Treatment is now recommended for all patients with chronic hepatitis C. Previously, hepatitis C treatment was prioritized by risk level, as defined by fibrosis stage and other patient characteristics.

- As before, patients who are confirmed to be HCV antibody-positive with positive RNA titers should be referred to a qualified HCV provider (a gastroenterologist or consultative or general internal medicine provider with training in hepatitis C treatment) for fibrosis staging and treatment decisions.
- At locations where there is not ready access to a Group Health HCV provider, patients should be referred to a contracted specialist in either gastroenterology or infectious disease.
- NEW IN THIS UPDATE: To guide treatment decisions, two lab tests (APRI and FibroSure) and a new imaging test (ARFI, or abdominal ultrasound with acoustic radiation force impulse) are now recommended.

- Patients at all stages who have elected immediate treatment will be followed up by an approved HCV provider at appropriate intervals, and will have their medication treatment supported by hepatitis C-certified trained clinical pharmacists in the Specialty Medication Program (SMP).

- NEW IN THIS UPDATE: For patients with hepatitis C who elect to defer treatment, surveillance will be done by an HCV provider. Previously, surveillance was done in Primary Care.

Questions?
John Dunn, MD, MPH, Assistant Medical Director, Preventive Care, dunn.jb@ghc.org
Avra Cohen, RN, MN, Guideline Coordinator, Clinical Improvement & Prevention, cohen.al@ghc.org

Check out Clinical Pearls on MyGroupHealth for Providers

Clinical Pearls are short, straightforward clinical recommendations you can integrate into your practice.
Site of Service Prior Authorization

GROUP HEALTH IS PARTNERING WITH CVS/CORAM to offer home infusion services to members currently receiving a select group of specialty medications in hospital outpatient infusion settings.

Value of Care Provided by CVS/Coram

- Knowledgeable care teams led by pharmacists and supported by infusion-trained nurses who are experts in the conditions and therapies they help manage and are available to patients 24 hours a day, seven days a week.
- Accredited by The Joint Commission as a home infusion provider.
- Demonstrated outcomes:
  - < 1% catheter complication rate
  - < 5% all-cause readmission rate
  (national average is 18.4%)
  - 96% member satisfaction

The most common drugs that will require site of service prior authorization are infliximab (Remicade) and immune globulin. Exceptions to the Site of Service Prior Authorization Criteria will be provided under the following circumstances:

- Member is medically unstable based upon submitted clinical history. Examples include but are not limited to: cardiopulmonary conditions that may increase risk of adverse reactions, inability to safely tolerate intravenous volume loads, unstable vascular access; or
- Previous experience of a severe adverse event following infusion. Examples include but are not limited to: anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure; or
- Continuing experience of adverse events that cannot be mitigated by pre-medications; or
- Physically and/or cognitively impaired and no home caregiver available; or
- The member’s home is not eligible for home infusion services (such as home is not within the service area or is deemed unsuitable for care by the home infusion provider).

NOTE: For new start patients, alternative Site of Service criteria will be waived for the administration of the first dose, to allow for adequate transition time to arrange for a non-hospital outpatient setting for the infusion. Some drugs may have further dose exceptions for new start patients; the full details will be posted before the effective date at MyGroupHealth for Providers. Clinical notes supporting an exception must be included (e.g. Dates of prior anaphylactic experience, specific details of adverse reactions and attempts to mitigate.)

Additional Information

A 60 day notice will be sent to all network providers containing the full criteria and a complete list of injectable drugs requiring prior authorization for hospital outpatient infusion setting. This will also be available before the effective date on MyGroupHealth for Providers.

To request prior authorization review, please use the Referral Request online form on the provider website listed above. You can also fax your request to Review Services toll-free at 888-282-2685.

Thank you for the care you provide to our members, your patients. If you have any questions about this process, please call Review Services at 800-289-1363.
Group Health Drug Formularies

THE GROUP HEALTH DRUG FORMULARIES are the cornerstone of medication therapy, quality assurance, and cost containment. The formularies are developed by the Pharmacy and Therapeutics (P&T) Committee. You can find the Formulary Decision Highlights from the most recent P&T Committee meetings at provider.ghc.org.

Group Health has six formularies:
The table below outlines some of the major differences in these formularies. A closed formulary design describes a formulary in which preferred medications are covered and non-preferred (non-formulary) medications are generally not covered. Coverage of non-preferred medications is available through an exception process. An open formulary design describes a formulary in which both preferred and non-preferred medications are covered; however, preferred medications are available at a lower cost share for patients.

To view the Group Health formularies:
• On MyGroupHealth for Providers—click on “Drug Formulary” in the left hand navigation.
• On ePocrates—register free of charge.

If you have questions about formulary status of a drug or prior authorization, please contact our Pharmacy Help Desk toll-free at 800-729-1174 or by fax toll-free at 866-510-1765.

INDIVIDUAL & FAMILY / SMALL GROUP MEDICARE FEDERAL EMPLOYEE HEALTH BENEFIT LARGE GROUP

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*Newly offered for 2016. Additional formulary information available at MyGroupHealth for Providers.
OptumRx is new claims processor for all Medicare Part D drugs

ON JANUARY 1, 2017, Group Health will be using a new claims processor, OptumRx for processing of all claims for Medicare Part D drugs. All members of Group Health Cooperative Medicare Advantage plans with Part D will receive a new member identification (ID) card as shown at right.

Beginning January 1, 2017, all claims for Part D covered medications must be sent directly to OptumRx for coverage. For Part D covered vaccines, members can be referred to a Group Health clinic or network pharmacy for purchase and administration of the vaccine. If a Part D covered vaccine or other medication is administered in the office, the member is responsible for paying full cost at time of service and then submitting the full cost of the item to OptumRx for reimbursement, minus the applicable cost share.

Medicare Part D vaccines are those that are of a preventive nature, such as the shingles vaccine, and are not already covered by Medicare Part B, such as pneumonia, flu, or other vaccines used to treat an injury or illness. There is no change for vaccines or other medications that are covered under Medicare Part B.

A list of Part D eligible vaccines can be found at medicare.ghc.org. Group Health Medicare members that need to submit receipts to OptumRx for reimbursement will be able to find a reimbursement form here as of 1/1/2017.

> GET 2017 REIMBURSEMENT FORMS

CONTINUING MEDICAL EDUCATION

Save these dates

Continuing Medical Education information is available at MyGroupHealth for Providers

HEAD TO TOE FOR PRIMARY CARE
Friday, February 3, 2017
Cedarbrook Lodge, SeaTac, Washington
To Register:
https://cmetracker.net/GHC/Catalog
Contact:
Christopher Scott, scott.cj@ghc.org

DIABETES FOR PRIMARY CARE
Friday, April 7, 2017
Cedarbrook Lodge, SeaTac, Washington
To Register:
https://cmetracker.net/GHC/Catalog
Contact:
Christopher Scott, scott.cj@ghc.org

WILDERNESS AND TRAVEL MEDICINE
Sunday, March 5 –
Wednesday, March 8, 2017
Delta Whistler Village Suites, Whistler, BC
To Register:
https://cmetracker.net/GHC/Catalog
Contact:
Maria Cardenas-Anson
cardenasanson.m@ghc.org