PruittHealth PREMIER

Provider Newsletter

Q2 2026

Don’t let outdated contact information get in the way

Keeping your provider information up to date helps members find and access care more easily. Please take a moment to review your Provider Directory listing and let us know about any changes as soon as possible—no later than 30 calendar days before the change takes effect.

pruitthealthpremier.com/find-a-provider

Need to update? Call or email Provider Network Services:

GA: **networksupport@pruitthealthpremier.com**

NC/SC: **networksupprt@pruitthealthpremier-nc.com**

Everything you need in one place

Our Plan website is your go-to resource for eligibility, benefits, billing and claims, credentialing, participation standards, and more. For a deep dive into the details, view our online Provider Manual and stay up to date on Plan requirements at **pruitthealthpremier.com/provider-manual**

Make your voice heard

Your feedback directly informs how we support your practice and the members you serve.. Please complete your Plan-specific survey below to share your thoughts on how we can better support you and your practice.

PruittHealth Premier Provider Survey 2026

2025 SNP Model of Care Performance Highlights

At PruittHealth Premier, our Medicare Advantage Special Needs Plan (SNP) Model of Care is designed to support members with complex or ongoing health needs. The Model of Care (MOC) provides a structured, team-based approach to care coordination that strengthens communication, improves transitions of care, and supports quality outcomes across settings.

2025 Plan Performance Overview

In 2025, the Plan demonstrated strong performance in several key Model of Care measures, reflecting meaningful collaboration with our provider partners and a continued focus on preventive, proactive, and coordinated care delivery.

Goals Achieved

- **Medication Review**
  Members received medication reviews to promote safe, effective, and clinically appropriate medication use.
- **Follow-up After Care Transitions**
  Members received timely post-discharge outreach and follow-up care, supporting safe recovery, continuity of care, and helping to reduce avoidable readmissions.
- **Adult Access to Preventive Care**
  Providers helped ensure members received an annual visit to reinforce early identification of health needs and long-term wellness.
- **Assessing Functional Status**
  Functional assessments were completed to better understand members' abilities and support care planning that aligns with daily living needs and overall quality of life.

Opportunity Identified

- **Hospital Admission Rate**
  The Plan is focusing on additional ways to support early care and coordination to help members stay healthy and avoid unnecessary hospital stays.

What Is the SNP Model of Care?

The SNP Model of Care establishes a framework that promotes consistent, coordinated care delivery. Key components include:

- Coordination across providers and care settings
- Individualized care planning aligned to member health needs
- Medication Management to support safe and effective medication use
- Interdisciplinary Care Team (ICT) collaboration

This approach aims to reduce gaps in care, enhance continuity, and improve overall outcomes for our members.

What This Means for Providers

These results show a Model of Care with strong foundations and clear opportunities for continued improvement. We remain committed to working closely with our provider partners to:

- Use performance results and feedback for ongoing refinement of care processes
- Support providers with tools and insights that enhance care delivery

Thank you for your continued partnership and dedication to the members we jointly serve. We look forward to building on this progress together.

Cultural Competency

CMS defines health equity as "the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes."

Participating providers must provide services to all Plan customers, consistent with the benefits covered in their policy, without regard to English proficiency or reading skills, ethnic, cultural, racial or religious background, mental or physical disabilities, sexual orientation, gender identity, socioeconomic or financial background, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, source of payment, or any other bases deemed unlawful under federal, state, or local law.

We encourage providers to visit the U.S. Department of Health and Human Services Office of Minority Health website for resources, training, policies, programs and best practices on Cultural and Linguistic Competency: **Cultural and Linguistic Competency | Office of Minority Health (hhs.gov).**

Compliance

Fraud, Waste, and Abuse (FWA) Monitoring

Our Plan has established robust policies and procedures to detect and prevent fraud, waste, and abuse (FWA) across all aspects of our network, including provider billing practices. These efforts support compliance with Medicare requirements and include coordination with CMS and law enforcement when necessary. We would like to remind you that as part of this work, we conduct routine analysis of CPT, ICD-9/ICD-10, and HCPCS coding to identify anomalies and ensure proper documentation. Participating providers must maintain accurate records and submit requested documentation promptly to avoid repayment obligations or regulatory referrals. Please respond to Plan medical record requests promptly. For more details, refer to the Provider Manual.

Compliance with Federal and State Laws

Our Plan is committed to full compliance with federal and state regulatory requirements applicable to our Medicare Advantage and Medicare Part D lines of business. Non-compliance with regulatory standards undermines Plan business reputation and credibility with the federal and state governments, subcontractors, pharmacies, providers, and most importantly, our members. Our Plan employees are also committed to meeting all contractual obligations outlined in Plan contracts with CMS. These contracts allow the Plan to offer Medicare Advantage and Medicare Part D products and services to Medicare beneficiaries.

The Corporate Compliance Program prevents violations of federal and state laws governing Plan lines of business, including but not limited to healthcare fraud, waste, and abuse laws. In the event such violations occur, the Corporate Compliance Program will promote early and accurate detection, prompt resolution, and when necessary, disclosure to the appropriate governmental authorities.

If you have compliance concerns or questions, call the **Compliance Hotline at 1-844-317-9059 (toll free).**

Provider Participation Standards

Please ensure your office remains compliant with key Plan participation standards. Full details are available on your **Plan website**, **Q1 Newsletter**, and in the **Provider Manual**.

Dual Eligibles & Cost Sharing

Do not bill dual-eligible members for Medicare cost-sharing when covered by the State. Accept Plan payment or bill the appropriate state source.

Member Hold Harmless

Balance billing is prohibited. Members may only be charged applicable copays, coinsurance, or non-covered services (per guidelines).

HIPAA & Patient Privacy

Always protect PHI and limit use to treatment, payment, and operations. Records must be provided upon authorized request.

Medical Record Standards & Retention

Maintain complete, accurate, and accessible records for all members for at least 10 years. Documentation must support quality care, coordination, and compliance.

Provider-Patient Communication

Providers may freely advise and advocate for patients. Members must be informed of all medically appropriate treatment options, regardless of coverage.

Anti-Discrimination & Cultural Competency

Provide equitable, respectful care to all members. Ensure communication is culturally competent and accessible, including interpreter/TTY services when needed.

Member Rights & Responsibilities

Respect member rights, including participation in care decisions, privacy, and access to services. Encourage members to understand and follow their Plan responsibilities.

Safe & Sanitary Environments

Maintain a safe care setting, including infection control, medication safety, and hazard prevention.

Access & Availability

Adhere to appointment access standards for all care types. Participation in annual access surveys is expected.

Marketing Compliance (CMS)

Remain neutral when discussing Plan options. Do not steer, limit, or influence beneficiary Plan selection.

Advance Directives

Honor and document advance directives. Do not discriminate based on a member's choices, and notify the Plan if accommodations cannot be met.

Provider Status by Health Plan

NEW SELF-SERVE CREDENTIALING STATUS TOOL

We have good news—there's now a faster, easier way to view provider credentialing status across all supported health plans in one place. Providers, and provider credentialing representatives can use the link below to review status without needing an account.

What to know

- No login required to access the page.
- Enter provider details and requester information to support data protection requirements.
- The status shown reflects credentialing status.

Credentialing Status Tool

Please note: To help protect sensitive information, you'll be prompted to enter both the provider's information and the requester's information. The status displayed is the credentialing status and is not a guarantee of payment. If you have claim-load–specific questions, the plan claims contact information is available within each provider record.

What is HEDIS?

The Healthcare Effectiveness Data and Information Set (HEDIS®) is one of health care's most widely used tools ion healthcare to measure quality and performance across health plans and provider organizations. Developed by the National Committee for Quality Assurance (NCQA), HEDIS includes standardized measures that evaluate how well patents are receiving preventative care, chronic disease management, and other essential services.

Why it matters to you as a provider:

- HEDIS measures directly impact health plan ratings and value-based performance
- They highlight gaps in care that can improve patient outcomes when addressed
- They rely on accurate and complete data submission, including supplemental data beyond claims

HEDIS Focus: Kidney Health Evaluation for Patients with Diabetes (KED)

The KED measure evaluates the percentage of patients ages 18-85 living with type 1 or type 2 diabetes who receive appropriate kidney health screening annually.

To close the KED gap, patients must complete BOTH:

- Estimated Glomerular Filtration Rate (eGFR)
- Urine Albumin-Creatinine Ratio (uACR)

Completing only one of these tests is not sufficient to close the gap, and both tests must be completed within the same measurement year. In practice, this is where many opportunities are missed - patients may complete routine lab work but lack the full combination of tests required. Closing this gap starts with intentional ordering and follow-through. Ensuring both tests are completed annually, confirming that appropriate codes are submitted, and leveraging supplemental data for services not reflected on claims, such as lab results and EMR documentation.

The following are a few approved codes to use that close the care gap:

Category	Code	Description
CPT	80047, 80048, 80050, 80053, 80069, 82565	Estimated Glomerular Filtration Rates
CPT	82043* and 82570*	Quantitative Urine Albumin and Urine Creatinine *Both tests should be from the same urine sample to produce a single ratio