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IN THIS ISSUE

WINTER 2023

PROVIDER RESOURCES

Most provider resources can be found on the provider page of the our website at www.centersplan.com/providers. The Quick Links section on the right of the web page offers easy access to forms, trainings, and plan stipulations.

CENTERS PLAN FOR HEALTHY LIVING

Scan the QR code provided to visit our website!

NEW UPDATE

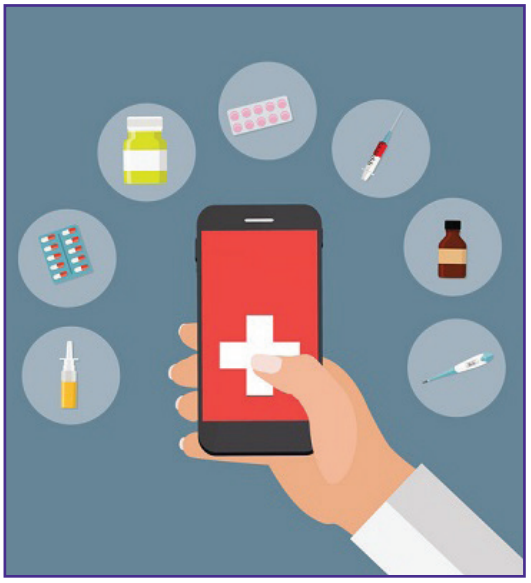
Provider Updates: Please Keep Us in the Loop

When was the last time you updated your information? Have you expanded and added a service location? Has your organization merged with another practice? Did you hire a new office manager or credentialing representative? Please let us know!

You can update your demographic information (location, ownership, NPI, contact information, etc.) by calling our Provider Hotline at 1-844-292-4211; emailing us at ProviderServices@centersplan.com; or scanning the QR code on the left.
Thank you in advance for your help in keeping our provider network information as accurate as possible!

Direct Secure Messaging for PCPs

As of September 2023, we can communicate via direct secure messaging! Our messaging system will be used to inform providers of patient hospital admissions and discharges. Depending on your EMR system, messages can go directly to your inbox or can be attached to a patient's record.



If you do not have a direct secure address, sign up now by requesting a direct secure address from your EMR administrator. If you need assistance with the process, please reach out to Secure Exchange Solutions at 1-888-470-9913.

Please Note: All providers with an NPI should have their Direct address listed in NPPES.
Be sure to check the NPPES list that is mailed to you or visit https://nppes.cms.hhs.gov.

Model of Care Training

In compliance with federal regulations, all contracted PCPs and specialists are required to complete annual basic training regarding our Special Needs Plan (SNP) Model of Care (MOC). Please visit our website to access our SNP MOC Training materials:

www.centersplan.com/providers

Fraud, Waste, and Abuse

Everyone is responsible for fighting fraud, waste, and abuse (FWA). If you suspect a provider, member, or Centers Plan staff person is engaged in fraud, waste, abuse, or any other questionable activity, you can anonymously report it:

- Call 1-855-699-5046; or
- Visit our website at www.centersplan.ethicspoint.com

Improving Medicare Patient-Reported Outcomes

You play a fundamental role in affecting patient perceptions surrounding their health and quality of life. Every year, the Centers for Medicare & Medicaid Services (CMS) sends the Health Outcomes Survey (HOS) to a random sample of Medicare members in the summer. Two years later, those same members are surveyed again to look at changes in their self-reported health outcomes. The HOS serves to provide a standardized understanding of patient outcomes around physical and mental health, fall risk and prevention, physical activity, and urinary incontinence.

Please follow the tips and techniques below to help you enhance your Medicare patients' health care outcomes:

1. **Assess symptoms of depression, anxiety, and other mental health conditions using a standardized, evidence-based, behavioral health screening tool**. If a patient screens positive on a tool or exhibits symptoms of a mental health condition, develop a plan with them to take steps to improve their mental health. Discuss exercise, stress triggers, sleep habits, connecting with supportive friends and family, and options for therapy with a mental health provider.

2. **Ask questions about overall physical well-being, functional status, pain, and any health status limits while performing daily activities (such as climbing stairs, working, etc.).** Determine if your patient could benefit from physical therapy, acupuncture, a pain management provider, case management services, or another specialist or service. Help link them to care, possibly with help from the Care Management team.

3. **Assess physical activity levels, including both aerobic and strength training activities.** Discuss the health benefits of staying active (e.g., mental health, physical functioning). Partner with your patients to set physical health improvement goals and to develop exercise strategies that match their abilities.

4. **Initiate discussions around urinary incontinence, and share educational materials about the condition.** Ask your patients if they have any trouble holding their urine, if they have had any accidents, and if urinary incontinence impacts their daily activities and quality of life (e.g., sleep, social situations). Explain how common urinary leakage is, especially as we grow older. Discuss treatment options such as pelvic exercises, dietary changes, bladder training, medicines, and surgery. Refer your patients to specialists, if needed (e.g., urologist, OB/GYN).

5. **Conducting fall risk assessments. You can use a tool like the "Stay Independent" assessment from the Centers for Disease Control and Prevention (CDC).** Ask questions about falls in the past year, feeling unsteady, and worries about falling. Discuss fall prevention interventions including exercise and balance activities, physical therapy, routine hearing and vision tests, and home safety interventions (e.g., grab bars in bathrooms, reducing trip hazards, use of nightlights).

6. **Conduct regular medication reviews.** Your medication reconciliation helps to ensure prescriptions are warranted, prevent dangerous drug interactions, and identify medications that may increase the likelihood of falls.

CMS's (V28) HCC Risk Adjustment Model

The Centers for Medicaid and Medicare Services (CMS) requires Medicare Advantage (MA) plans to participate in their Risk Adjustment and Hierarchical Condition Category (HCC) coding payment system. This coding payment model was designed to identify serious or chronic illnesses and assign a risk factor score to the member, based upon a combination of their health conditions and demographic details to better describe a member' s acuity of illness.

When you submit a visit claim, the diagnosis codes attached to the claim are ultimately transmitted to CMS, where the diagnoses are converted into HCCs based on a risk adjustment model. CMS updated the twenty-eighth version (V28) of the HCC risk adjustment model to utilize ICD-10 codes and to include clinically-based adjustments that ensure more complex conditions requiring intensive and ongoing management are captured. In the updated model, CMS expanded and adjusted existing categories, as well as introduced eight new condition categories, bringing the total to 115 HCCs.

The new condition categories are as follows:

1. Benign Carcinoid Tumor (multiple sites)
2. Other Benign Neuroendocrine Tumors
3. Sarcoidosis of Skin
4. Birth Trauma, Maternal Use of Drugs, Newborn Problems, and Disorders Specific to the Perinatal Period
5. Post-polio Syndrome
6. Severe Persistent Asthma
7. Obstructions of Bile Duct
8. Anorexia Nervosa and Bulimia Nervosa

Meticulousness in documentation helps ensure that the current clinical condition is accurately captured and the appropriate HCC category is attributed to the patient. Unspecified codes should be avoided as often as possible and used only when a specific condition is not supported and documented. If a specified condition is supported and documented, providers should use an alternative specific code within the appropriate ICD-10 category rather than select an unspecified descriptor and use nebulous codes. Following are a few additional documentation tips to keep in mind.

Periodic updates to the risk adjustment HCC model are designed to provide an accurate representation of patient health and reflect the ever-changing complexities of patient care. We are grateful for your ongoing partnership in providing exceptional patient care and anticipate that the changes described in the updated risk adjustment HCC model will better capture the acuity of the patients that we mutually serve.

More information regarding this updated risk adjustment HCC model can be found in the 2024 announcement: https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/announcements-and-documents/371979854/2024

Risk Adjustment Documentation Tips

Please use the following as a guide to what key elements of medical record documentation would be most critical for some of the more commonly encountered clinical conditions.

Please DOCUMENT the following in the MEDICAL RECORD, as applicable:	
Severity	• Mild, moderate, severe
Laterality	• Right, left, bilateral
Status	• Active, in partial remission, in full remission
Other and Other Specified	• Specific condition that is not captured in exiting codes and warrants the use of an "other" code
Please ALSO DOCUMENT DISEASE-SPECIFIC matters in the MEDICAL RECORD, as applicable:	
Major Depressive Disorder	• Severity: mild, moderate, severe without psychotic features, or severe with psychotic features • Frequency: recurrent or a single episode
Dementia	• Description of behavioral disturbance(s), such as agitation, sleep disturbances, and wandering • Description of psychotic disturbance(s), such as hallucinations and paranoia • Description of mood disorder(s), such as apathy, depression, and anxiety

Chronic Kidney Disease (CKD)	• Stage – AND – associated glomerular filtration rate (GFR):
	  • Stage 1 with normal or high GFR (GFR > 90 mL/min)
	  • Stage 2 Mild CKD (GFR = 60-89 mL/min)
	  • Stage 3a Moderate CKD (GFR = 45-59 mL/min)
	  • Stage 3b Moderate CKD (GFR = 30-44 mL/min)
	  • Stage 4 Severe CKD (GFR = 15-29 mL/min)
	  • Stage 5 End Stage CKD (GFR <15 mL/min)

Heart Failure	• Type: left-sided systolic, left-sided diastolic, right-sided, or congestive heart failure • Stage: A, B, C, or D • Class: I, II, III, or IV • Presence of a heart assist device or artificial heart, if present
Cancer	• Site of the cancer, including primary and secondary locations • Type of tumor, if applicable: benign, premalignant, or malignant • Status: active, partial remission, or full remission • Presence of active or prophylactic treatment, as well as refusal of treatment
Please CONSIDER the following, as applicable:	
Acute Stroke	• This code should only be used in a hospital setting. • In an outpatient setting, a diagnosis of a history of stroke should be used.
Acute Myocardial Infarction	• This code is generally used in a hospital setting and can only be used in an outpatient setting within 4 weeks after the acute episode. • A diagnosis of a history of myocardial infarction should be used in an outpatient setting after 4 weeks from the acute episode.
Embolism	• Anticoagulant therapy is typically used to treat an acute or active embolization. • In instances where a patient has a history of embolism and the provider is evaluating a prior acute embolism and anticoagulant medication is not prescribed during the visit, a diagnosis of history of embolism should be used.

Primary Care Provider (PCP) Incentive Program

Centers Plan's Primary Care Provider (PCP) Incentive Program rewards PCPs for providing quality care to our members and partnering with us improve health outcomes. Eligible PCPs can receive $250 per member per year.

Centers Plan's PCP Incentive Portal registration is still open. Follow these simple steps to register and receive your incentive:

1. Register on our PCP Incentive Program portal: www.centersplan.com/PCPincentive
2. Document clinically appropriate measures in patient files.
3. Submit applicable medical records* to Centers Plan using the PCP Incentive Program Portal.
4. Claim an annual incentive for each of your eligible members.

You can use our PCP Incentive Portal to see which of your members are eligible for an incentive; track progress on submissions that you've made; and follow-up on any missing documentation as requested. Eligible PCPs have until February 29, 2024 to submit all required documentation and medical records in order to qualify for the 2023 incentive.

If you have questions, we're here to help! Please contact the Provider Hotline at 1-844-292-4211 (711 for TTY users) or ProviderServices@centersplan.com. Representatives are available to assist you Monday through Friday, 9 am to 5 pm.

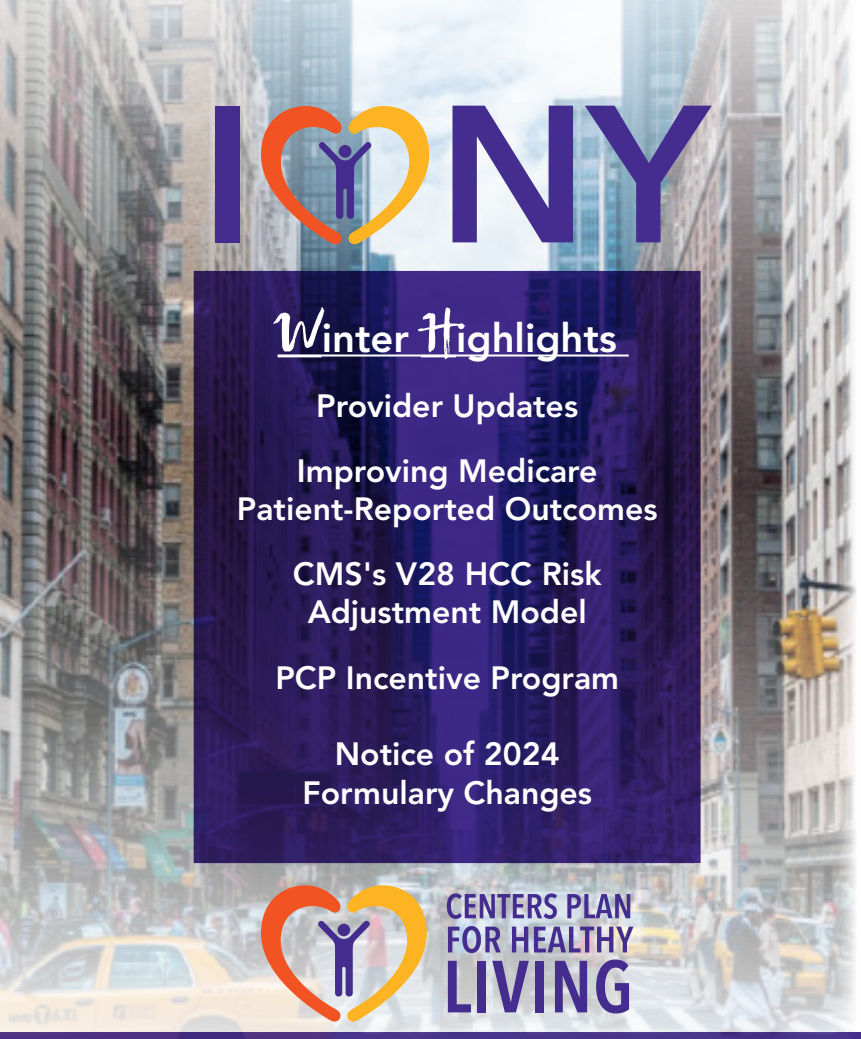
* The following measures (as clinically appropriate) must be completed in 2023 in order to qualify for this year's PCP Incentive Program:
  - Annual Wellness Visit
  - Body Mass Index (BMI)
  - Blood Pressure
  - Mammogram education and referral
  - Colonoscopy education and referral
  - Diabetes Screenings:
    - o A1C
    - o Kidney health evaluation (eGFR and uACR)
    - o Retinal Eye Exam

Notice of 2024 Formulary Changes

We would like to notify you that **effective January 1st 2024, Center's Plan will no longer have the following BRAND medications on formulary**. Instead of covering these brand medications, **our plan will cover their generic alternatives.** The names of the covered alternatives for 2024 are indicated next to each medication.

Novolog (brand) – Insulin aspart
Advair Diskus - Advair HFA or Wixela Inhub
Symbicort - Breyna HFA or Budesonide/formoterol HFA inhaler
Flovent HFA - Fluticasone propionate HFA

Please send new prescriptions for generic alternatives to pharmacies of the affected members. Please educate your patients about these formulary changes and on therapeutic equivalency of the covered alternatives to facilitate this transition.
We appreciate your concern and attentiveness to this matter.



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Winter Highlights

Provider Updates

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CMS's V28 HCC Risk Adjustment Model

PCP Incentive Program

Notice of 2024 Formulary Changes

CENTERS PLAN FOR HEALTHY LIVING

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Winter 2023

CPHL Contact Guide

Provider Hotline: 1-844-292-4211 | Monday – Friday | 9AM – 5PM

Department		
Utilization Management UM@centersplan.com	Press 1 for Service Authorizations	
Claims: Claims@centersplan.com All claims must be received within the time frame specified in your provider agreement. Please be sure to include your NPI and TIN on all claims	Press 2 for Claims Please Mail Paper Claims to: Centers Plan for Healthy Living P.O. Box 21033 Eagan, MN 55121	Electronic Claims Submissions: Payor ID: CPHL or CPHL1 To set up electronic submissions directly to CPHL, Contact Claims Department.
Member Eligibility MemberServices@centersplan.com	Press 3 for Member Eligibility	
Provider Services ProviderServices@centersplan.com	Press 4 for any other Provider Services Inquiries	

Member Services: 8AM – 8PM | 7 Days a week | MemberServices@centersplan.com

Lines of Business	Phone Number
Medicare Advantage Care (HMO)	1-877-940-9330
Nursing Home Care (ISNP)	1-877-940-9330
Dual Coverage Care	1-877-940-9330
Medicaid Advantage Plus (MAP)	1-833-274-5627
Managed Long-Term Care (MLTC)	1-855-270--1600

Pharmacy Services

Access our website at www.centersplan.com for our Formulary Listing.	
Part D drugs are administered through our Pharmacy Benefit Manager, MedImpact	MedImpact Customer Service: 1-888-807-5717

Behavioral Health Services

If your patient/our member:	Please Contact:
May need behavioral health services	Centers Plan Provider Services: 1-844-292-4211; Press 4 and ask for Care Management
Is currently receiving behavioral health services through CPHL	Carelon Healthcare Services: 1-877-461-0060