Provider Check Up

Partner up with Health Partners Plans!

HPP Participating Providers Newsletter | **WINTER 2020**

Complete Your Medicare Compliance Attestation Reminder

Thank you for being a Health Partners Plans (HPP) participating provider. In June, you received a letter from HPP regarding the Medicare Provider Compliance Attestation and your obligation to review and complete it within 30 days. If your organization has not yet completed the Medicare Provider Compliance Attestation, we respectfully request that you complete this attestation as soon as possible.

The Centers for Medicare & Medicaid Services (CMS) requires First Tier entities, including contracted providers, to complete and submit a Medicare Compliance Attestation annually. As a Medicare Advantage plan, HPP is required to ensure that our Medicare providers comply with CMS's Compliance Program requirements.

Please complete your Provider Compliance Attestation as soon as possible. You can complete the form online at hpplans.com/providerattestation. The attestation form is required at the contract level* by completing the following sections:

1. Code of Conduct and Compliance Policies for Contracted Health Care Providers

The Code of Conduct states the overarching principles and values by which the organization operates, and defines the underlying framework for the compliance policies and procedures. The Code of Conduct and compliance policies describe your organization's expectations that all employees conduct themselves in an ethical manner; that issues of noncompliance and potential Fraud, Waste and Abuse (FWA) are reported through appropriate mechanisms; and that reported issues will be addressed and corrected. The Code of Conduct and compliance policies communicate to employees of your organization and those of your downstream entities (if applicable) that compliance is everyone's responsibility from the top to the bottom of the organization. HPP complies with CMS's distribution of the Code of Conduct and compliance policies requirements. As a First Tier provider who contracts with HPP to provide health care services for our Medicare business, you are required to distribute the Code of Conduct and any additional compliance policies to all of your organization's employees and those of your downstream entities who provide services for HPP within 90 days of hire or contracting and annually thereafter.

Most organizations already have and utilize their own Code of Conduct and/or compliance policies to communicate the organization's expectations that all employees conduct themselves in an ethical manner; that issues of noncompliance and potential FWA are reported through appropriate mechanisms; and that reported issues will be addressed and corrected. We also provide access to our Code of Business Conduct and Compliance Policies (referred to as Medicare Compliance Program). You can access these documents online at **hpplans.com/providerattestation**. These documents are also included in Chapter 13 of our Provider Manual, located online at **hpplans.com/providermanual**.

In order to be compliant with this requirement, you must ensure that your organization **either** adopts and complies with HPP's Code of Conduct and Compliance Policies **OR** has its own Code of Conduct and/or Compliance Policies that are materially similar. You are required to distribute the Code of Conduct and any additional compliance policies to all of your organization's employees and those of your downstream entities (if applicable) who provide services for HPP within 90 days of hire or

contracting and annually thereafter.

When completing the attestation, you must select **one** of the following options:

- **My organization adopts and complies with HPP's Code of Conduct and Compliance Policy.**
- **My organization has adopted another policy that is materially similar to the HPP Code of Conduct and Compliance Policy and complies with that policy.**

If your organization does **NOT** have a Code of Conduct/Compliance Policy, and has not adopted HPP's, please be sure to provide an explanation in the text box.

2. Organizations with Downstream Entities

Note: *This section is only applicable to organizations that have contracted with downstream entities who are assigned to work on HPP's business. If you do NOT have contracted downstream entities, indicate "My organization does not contract with any downstream entities who are assigned to work on HPP's business."*

The above stated "Code of Conduct and Compliance Policies for Contracted Health Care Providers" requirement also applies to downstream entities who are assigned to work on HPP's business. This means, as a First Tier provider who contracts with HPP to provide health care services for our Medicare business, you are required to distribute the Code of Conduct and any additional compliance policies to all of your organization's employees and those of your downstream and related entities who provide services for HPP within 90 days of hire or contracting and annually thereafter.

In order to comply with this requirement, your organization may choose to adopt any of the following approaches:

- **Ensure downstream entities who are assigned to work on HPP's business receive HPP's Provider Manual, which includes HPP's Code of Conduct and compliance policies.**
  - HPP provides access to HPP's COC and compliance policies via the Provider Manual. Furthermore, HPP ensures the documents are readily available on HPP's Medicare First-Tier, Downstream, and Related entities (FDR) Webpage.
- **Ensure downstream entities who are assigned to work on HPP's business receive your organization's Provider Manual, which includes your Code of Conduct and compliance policies.**
- **Ensure your downstream entities who are assigned to work on HPP's business receive your organization's Code of Conduct and compliance policies as documents separate from any Provider Manual you may have.**
- **Ensures downstream entities have been contractually required to have and distribute their own Code of Conduct and compliance policies. If your downstream entities utilize their own comparable versions, your organization should conduct a review of those policies from a sample of downstream entities to ensure the content is sufficient.**

Reminder: *If you do NOT have contracted downstream entities, only select "My organization does not contract with any downstream entities who are assigned to work on HPP's business."*

3.OIG/SAM Exclusion Screenings

In order to be compliant with this requirement, your organization must review the OIG-LEIE and SAM-EPLS prior to the hiring or contracting of all personnel involved in the administration or delivery of HPP benefits and on a monthly basis thereafter.

4. Necessary Reporting Mechanisms

Your organization must ensure employees and downstream entities (if applicable) are aware of their obligation to report any suspected or detected non-compliance or potential FWA for internal investigation. Your organization must ensure employees and downstream entities are able to report such concerns without fear of retaliation or intimidation. Additionally, your organization must report any applicable incidents to HPP as they arise.

Your completed provider compliance attestation form will be submitted to a secure, routinely monitored email address. Learn more at **hpplans.com/medicare-fdr-info**.

If you are a provider office or group with multiple entities, you only need to submit one form to complete

your annual compliance requirement. A new attestation must be completed annually to successfully meet your contractual obligation for 2020, as a completed 2019 attestation cannot be applied to your 2020 requirement.

This attestation is unique to Health Partners Medicare and completing it does not satisfy your obligations with other health plans with whom you are contracted with. Health Partners Medicare providers who fail to complete this annual requirement may be subjected to completing a process improvement plan.

If you have any questions, contact your NAM (Network Account Manager) or the Provider Services Helpline at **1-888-991-9023** (Monday to Friday, 9 a.m. to 5:30 p.m.).

Thank you for being an HPP participating provider and for your anticipated partnership in providing great service to our members.

**If you are a new provider that is affiliated with a group that is currently contracted with HPP, this does not apply to you.*

Teen Pregnancy Prevention with Long Acting Reversible Contraceptives (LARC)

Teen pregnancy can impose substantial health, social and economic costs (immediate and long-term) on teen parents and their children. Fortunately, the CDC recently reported that nearly 90% of sexually active teens use contraception. The most favorable contraceptive methods for teens are intrauterine devices (IUDs) and implants, known as Long-Acting Reversible Contraception (LARC). These are the most effective and safe types of contraception for teens and reliably prevent pregnancy for 3-10 years without the need to remember or initiate contraception. LARC is effective first-line choice of birth control for teens according to clinical guidelines for adolescents from the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics.

In order to increase access to contraception and awareness of LARC methods, HPP asks that providers do the following:

- **Educate teens on available contraceptive methods and emphasize the method is a personal choice**
- **Offer a broad range of birth control options to teens, including LARC, and discuss the pros and cons of each method**
- **Provide prevention services to teens at every visit, recognizing LARC as a safe and effective first-line choice of birth control for teens**
- **Seek training in LARC insertion and removal, have LARC supplies available and explore funding options to cover costs**
- **Provide same-day initiation if possible, to decrease the risk of unwanted pregnancy**
- **Remind teens that LARC do not protect against sexually transmitted diseases and condoms should also be used every time they have sex**

Resource: https://www.cdc.gov/vitalsigns/larc/index.html

Provider Education: COVID-19 and its Potential to Increase Antimicrobial Resistance

While the exact relationship between the rise in antimicrobial resistance and COVID-19 is unknown, multidrug resistant (MDR) bacteria have the potential to be the next healthcare crisis. A secondary bacterial infection caused by MDR bacteria can complicate the hospitalization of COVID-19 patients, and patients most vulnerable to COVID-19 have overlapping risk factors for acquiring MDR bacterial infections.

In January 2020, the World Health Organization (WHO) issued a warning regarding the rise of drug resistant infections. Due to the lack of innovation and development of new pipeline antibiotics, the WHO warns that the threat of drug resistant infections has never been more urgent. Most pipeline antibiotics have intolerable toxicities or have minimal benefit over current treatment options. While this warning has taken a backseat to the coronavirus pandemic, strains of MDR bacteria are still on the rise.

What can you do to prevent the rise of MDR bacterial infections?

Verify antibiotic true allergies: 10% of the population reports a penicillin allergy but <1% of the whole population is truly allergic and approximately 80% of patients with IgE-mediated penicillin allergy lose their sensitivity after 10 years

- **How to identify a true IgE-medicated allergy:**
  - Characteristics of an IgE-mediated reaction include:
    - Reactions that occur immediately or usually within one hour
      - Hives: Multiple pink/red raised areas of skin that are intensely itchy
      - Angioedema: Localized edema without hives affecting the abdomen, face, extremities, genitalia, oropharynx or larynx
      - Wheezing and shortness of breath
      - Anaphylaxis: Anaphylaxis requires signs or symptoms in at least two of the following systems:
        - Skin: Hives, flushing, itching, and/or angioedema
        - Respiratory: Cough, nasal congestion, shortness of breath, chest tightness, wheeze, sensation of throat closure or choking, and/or change in voice-quality (laryngeal edema)
        - Cardiovascular: Hypotension, faintness, tachycardia or less commonly bradycardia, tunnel vision, chest pain, sense of impending doom, and/or loss of consciousness
        - Gastrointestinal: Nausea, vomiting, abdominal cramping and diarrhea

Keep up to date vaccines readily available: Vaccination against pneumonia can prevent the spread of infection and the overuse of antibiotics.

- **CDC recommends PCV13 for:**
  - All children younger than 2 years old
  - People 2 years or older with certain medical conditions*
- **CDC recommends PPSV23 for:**
  - All adults 65 years or older
  - People 2 through 64 years old with certain medical conditions*
  - Adults 19 through 64 years old with diabetes, chronic lung disease (including asthma) or who smoke cigarettes

**Medical conditions include cochlear implants, cerebrospinal fluid leaks, functional or anatomic asplenia, and immunocompromising conditions like HIV infection, cancer, or chronic renal failure.*

Practice watchful waiting: Watchful waiting is a technique that prevents the use of antibiotics in patients who can fight the infection on their own. By utilizing a watchful waiting prescription pad, the patient does not need to schedule an additional appointment to fill the antibiotic. Since infections caused by the common cold or flu typically last 7-10 days, the watchful waiting technique can prevent the use of antibiotics for viral infections.

Educate patients to take full course of antibiotics: Remind patients that they will likely start to feel better before the course of antibiotics is finished. Completing an antibiotic regimen is one of the easiest and most effective ways to prevent new strains of multi drug resistant bacteria.

References:

1. 2019 Antibacterial agents in clinical development: an analysis of the antibacterial clinical development pipeline. Geneva: World Health Organization; 2019. Licence: CC BY-NC-SA 3.0 IGO.
2. Joint Task Force on Practice Parameters representing the American Academy of Allergy, Asthma and Immunology; American College of Allergy, Asthma and Immunology; Joint Council of Allergy, Asthma and Immunology. Drug allergy: an updated practice parameter. Ann Allergy Asthma Immunol. 2010 Oct;105(4):259-273.
3. Freedman MS, Hunter P, Ault K, Kroger A. Advisory Committee on Immunization Practices Recommended Immunization Schedule for Adults Aged 19 Years or Older — United States, 2020. MMWR Morb Mortal Wkly Rep 2020;69:133–135. DOI: http://dx.doi.org/10.15585/mmwr.mm6905a4
4. Chow AW, Benninger MS, Itzhak B, et al. IDSA clinical practice guideline for acute bacterial rhinosinusitis in children and adultsExternal. Clin Infect Dis. 2012;54(8):e72-e112.

Clinical and Preventive Guidelines

In order to best serve our providers, Health Partners Plans (HPP) offers various resources and links to clinical and preventive guidelines on the HPP provider website. The guidelines include examples of evidence-based practices available for health care providers to reference, specifically preventive guidelines for pediatric, adult and elderly wellness care and recommended screenings with information on disease states such as diabetes, COPD and heart disease.

If you would like a hard copy of any clinical or preventive guidelines, contact the Provider Services Helpline at 1-888-991-9023 and a copy will be sent to you.

Encouraging Teledentistry as an Option During the Pandemic

The COVID-19 pandemic has made many people hesitant to visit their healthcare providers for routine care and emergencies and dental care is no exception. While the American Dental Association supports routine dental care in the office, telehealth can provide a safe alternative for your patients.

Within our healthcare system, there is a large number of people who are not receiving dental care and as a result, must turn to hospitals and emergency rooms for issues like toothaches. Unfortunately, these types of oral health problems cannot be treated in an emergency room and people are sent home with unresolved issues.

Teledentistry can help to facilitate the delivery of dental services to treat these common issues by using technology to determine if a person has an urgent or emergency dental condition and whether or not that condition can be treated remotely or will require an additional in office visit for further assessment. Similar to medical telehealth visits, the patient only requires a smart phone or computer with video capability to access this convenient service.

The Pennsylvania Department of Health has extended teledentistry coverage to ensure that all dental and oral health issues are addressed, even amidst the pandemic. If your patients have a dental problem or complaint, encourage them to speak with their dentist about teledental visits.

Reporting Conditions to the Pennsylvania's Department of Health – PA-NEDSS

As a reminder, all hospitals, laboratories, providers and public health staff are required by law to report certain conditions to the Commonwealth of Pennsylvania's Department of Health (PA DOH).

This requirement is outlined in Chapter 27 (Communicable and Noncommunicable Diseases) of the Pennsylvania Code (28 Pa. Code § 27.1 et seq), and on its 2003 addendum (33 Pa.B. 2439, Electronic Disease Surveillance System), located on the official Pennsylvania Code website.

Providers must report the required diseases/conditions to the PA DOH through Pennsylvania's version of the National Electronic Disease Surveillance System, known as PA-NEDSS. Please note that first-time users must register on the PA-NEDSS website in order to use the reporting tool.

Please note: If you are a public health staff member (as defined by PA DOH), you and your supervisor must complete the PA-NEDSS Authorization Request Form to obtain access to PA-NEDSS. Contact the PA-NEDSS Help Desk at 717-783-9171 or via email at ra-dhNEDSS@pa.gov for the appropriate version of this form.

Additional Resources:

- PA-NEDSS New User Guide
- Listing of PA reportable conditions **(revised March 2012)**
- Pennsylvania Case Definitions
- Pennsylvania Code website

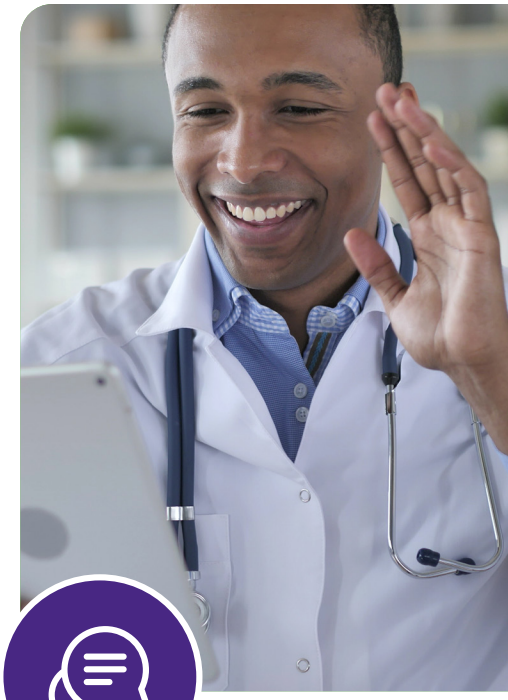
Final Reminder: Complete Quarterly Orientation and Training by December 31, 2020

Each year, HPP providers are required to participate in an informational provider orientation. This training is offered once each quarter via a live webinar. In addition to the webinar, there are two alternative methods for completing the required training:

- **Request a face-to-face training by emailing providereducation@hpplans.com.**
- **Download an electronic copy of the 2020 training to review with your staff. Simply review the information, complete the attestation and click "submit" to complete the requirement by December 31, 2020.**

Register now for an upcoming quarterly provider orientation and training for new and existing providers at **Webinars | Health Partners Plans. The final training for this year is December 9 at 12:30 p.m.**

Cultural Competency and Linguistic Requirements and Services



Cultural competency is a primary ingredient in closing the disparities gap in health care. It requires a commitment from physicians, nurses, social workers, community health workers, caregivers and all office staff personnel to understand and be responsive to the different attitudes, values, verbal cues and body language that patients look for in their physicians' offices.

To learn more, we encourage physicians and staff to review a comprehensive presentation that addresses:

- **Racial health disparities in the Philadelphia area**
- **LGBTQ+ experiences in health care settings**
- **Cultural competence**
- **The provider's role with LGBTQ+ patients**
- **National CLAS standards**
- **Resources and more**

You can find the Cultural Compentency and Lingustic Requirements and Services presentation here: Presentation | Recording (Password: bR8cZ3Jp)

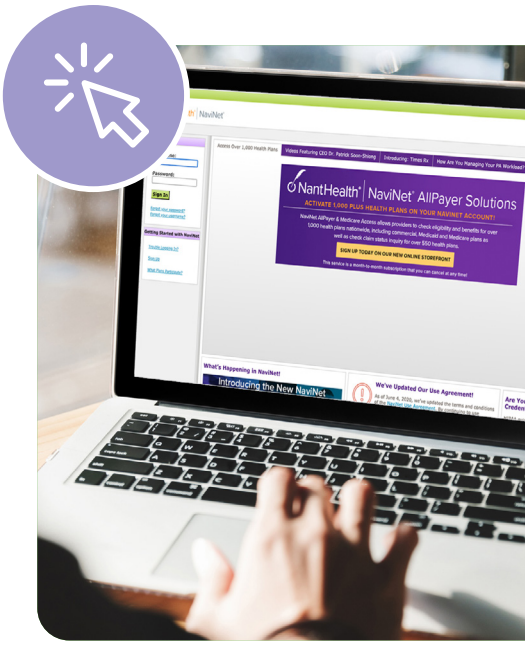
Reminder to all Medicare Advantage Plan Participating Providers

Health Partners Plans would like to remind providers of the importance of validating your provider data using the Provider Data Validation Form (PDVF) process. As a Medicare Advantage plan, HPP is required to validate our provider data on a quarterly basis per a 2016 Centers for Medicare and Medicaid Services (CMS) regulation. The regulation ensures that members are able to access health care services without encountering barriers (e.g., making sure that office addresses, patient hours, practitioner names and panel statuses are correct), and requires participating providers to work with HPP each quarter to validate the provider data we have on file.

On a quarterly basis, HPP reaches out to all participating Medicare Advantage providers via NaviNet with our current PDVF process.

Below are the steps providers receive quarterly to ensure compliance with the PDVF process:

1. **Log on** to NaviNet at https://navinet.navimedix.com/
2. **Click** on Workflows > Practice Documents
3. **Scroll** to find PDVF listed under Financial Report
4. **View and print** the report*
5. **Make any required changes** to the data presented on the report
6. **Sign and Date** the form (even if no changes are made)
7. **Return** the signed and dated form to HPP



**If you receive a "No practice documents found" message in NaviNet, your Security Officer will need to follow the instructions below:*

1. On the NaviNet toolbar, **select** Administration
2. **Click** Manage User Permissions
3. On the User Search screen, **select** the user whose permissions you would like to change
4. **Click** Edit Access
5. If you participate with multiple MCOs, you must first select Health Partners Plans, then scroll down to **enable** the Financial Reports.

Each provider office is required to validate the information listed on the provider profile and respond to the request even if the data is correct and has not changed.

Profiles are based on the TAX ID (TIN) and should include all providers and practice locations associated with the TIN. The data included on your profile is the same data that appears in our online provider directory used by our members.

The profile is separated into two sections:

- Section 1: Practice Level
  This section requires participating providers to validate the practice-level information, including the list of providers practicing at each location.
- Section 2: Provider Level
  This section requires participating providers to validate the provider-level information, including data elements, such as languages spoken and age ranges.

It is critical that HPP receives a response from our participating providers with changes or attesting that no changes are required. No response from the provider is confirmation that the information presented is accurate.

Join the Credentialing Committee of Health Partners

Heath Partners Plans needs a participating/PAR provider to join our monthly credentials committee meeting. The Credentialing Committee of Health Partners is responsible for reviewing applications of candidate practitioners applying to participate in Health Partners, and assuring that such candidates meet the Credentialing Standards in effect at the time of review. The Committee is also responsible for reviewing the recredentialing of participating practitioners, reviewing their files and assuring that the practitioners meet recredentialing standards. Members of the Credentialing Committee of Health Partners are given a stipend for participating during the meeting. The committee meets remotely once per month.

If you are interested in joining the Credentialing Committee of Health Partners or would like more information, please reach out to the credentialing departments management team:

- **Christopher Martinez, Director of Credentialing & Provider Data Management – cmartinez@hpplans.com**
- **Ada Nieves, Manager of Credentialing - anieves@hpplans.com**

Fast Facts: Medicare Health Outcomes Survey (HOS) Improving or Maintaining Physical Health

- **What:** The Medicare HOS is sent to a random sample of members between April and July
  - Members are surveyed again two years later (for members that remain with the plan)
- **Who:** Members aged 65 or older whose physical health was better, same or worse than expected after two years.

Performance Rating Measure Set:
Medicare Stars Rating; Improving or Maintaining Physical Health is triple-weighted

Background:
Multiple factors impact this important and heavily weighted measure. The HOS question about pain has the highest impact on the score. The other drivers are self-rated health and mobility. Changes are measured over a two-year period.

Providers Should Ask Medicare Patients:

- **Your physical health affects your ability to get around and live independently. Does your health stop you from doing your daily activities?**
- **During the past four weeks, has pain stopped you from doing the things that you want to do?**
- **Why:** Deteriorating health not only impacts patients' physical health but can also cause mental health issues like depression. Help patients take an active role in their health by discussing their physical health concerns and talking through any necessary action planning, including goal setting to improve or maintain their health.

Tips for Providers:

- **Implement a pre-visit checklist to better address past issues or concerns your patient has raised during previous visits.**
- **Ask about the patient's upcoming appointment schedule and have his/ her lab work results available. By having results available during the appointment, patients can participate in the decision-making and are more likely to follow treatment recommendations.**
- **Routinely assess patients' pain and functional status using standardized tools.**
- **Provide interventions to improve physical health, such as disease management, pain management and referrals to physical therapy.**

Fast Facts: Medicare Health Outcomes Survey (HOS) Improving Bladder Control

- **What:** The Medicare HOS is sent to a random sample of members between April and July
- **Who:** Members aged 65 or older who had a problem with urine leakage in the past 6 months, who discussed it with their doctor and received treatment during the year.

Performance Rating Measure Set:
Medicare Stars Rating; Improving Bladder Control; 1x weighted

Background:
Bladder control issues affect the daily lives of an estimated 17 million Americans, who suffer from involuntary leakage of urine, also known as urinary incontinence. In adults 65 and older, up to 32 percent of men and 39 percent of women suffer from urinary incontinence (Shamliyan et al., 2007).

Providers Should Ask Medicare Patients:

- **In the past six months, have you experienced leaking of urine?**
- **Have you discussed treatment options with a doctor or other health care provider?**
- **Why:** Adults in general may be uncomfortable and embarrassed to discuss this topic with their providers. Seniors who experience urinary incontinence may socialize less, and become less independent. Some adults report worse physical health, mental health and quality of life. Discussing bladder control issues with patients can help address and reduce symptoms with practices, procedures, programs or policies that have been proven effective.

Tips for Providers:

- **Initiate the discussion of bladder control with patients and ask if it has affected their daily life or sleep.**
- **Recommend exercises and discuss treatment options or other interventions. Interventions may include:**
  - medication therapies
  - behavioral therapies electrical stimulation
  - surgical and palliative/supportive treatments or lifestyle recommendation changes
- **Determine if your patents need to follow up with a Urologist.**

Claim Billing Instructions

Health Partners Plans is required by State and Federal regulations to capture specific data regarding services rendered to its members. All billing requirements must be adhered to by the provider in order to ensure that required data is captured. To be accepted as a valid claim, the submission must contain correct current coding, including but not limited to CPT, HCPCS, DRG, Revenue and ICD-10 codes and modifiers.

For all Health Partners Plans products, Hospitals must follow CMS requirements for billing 340B modifiers under the hospital outpatient prospective payment system. All claims for drugs and biologicals purchased through the federal 340B Discount Drug Program must be billed on a separate claim line with the appropriate 340B modifier (i.e. “JG” or “TB”). Hospitals that participate in the 340B Program must maintain documentation in accordance with CMS requirements and comply with applicable reporting requirements. Depending on the provider’s contract with Health Partners Plans, the reporting of 340B modifiers may impact fee schedule allowances or be collected for informational purposes only.

It’s Not Too Late for the Flu Vaccine!

Please advise your patients to receive the flu shot if they have not already. It is crucial for everyone six months or older to get a flu vaccine this year. Flu vaccination is an important step in helping to reduce the impact of respiratory illness and resulting burdens on the healthcare system during the pandemic.

Please note: HPP now covers Medicaid patients ages 9-19 to get their flu shots with a prescription at participating vaccine network pharmacies. (Medicaid members aged 19 and older are still eligible for the flu vaccine at participating vaccine network pharmacies.) Please reach out to your NAM for additional information.