Provider Check Up

Partner up with Health Partners Plans!

HPP Participating Providers Newsletter | **FALL 2021**

A New Feature in our HP University

Provider Education Self-Management Tools Certificate Program

HP University online classes were created to keep you informed on a variety of important topics. Those who complete an online course will receive a printable certificate of completion. Those who complete three courses will receive acknowledgement of their practice in our quarterly newsletter. (Please note: one of the courses must be the Provider Annual Orientation and Training). **Click on a course below to start.**

Provider Orientation and Training

Providers who are contracted with Health Partners Plans (HPP) must demonstrate that they are knowledgeable and trained on important topics annually. Participation in our quarterly provider orientation and training course satisfies this annual requirement. The course offers a detailed overview of HPP and gives valuable information to meet the needs of our members. Topics include: claims information, member ID cards, online tools and prior authorization guidelines.

Timely Filing Protocols and The Reconsideration Process

This course provides an overview of Health Partners Plans 180 calendar day process for submitting or resubmitting claims for proper review and/or processing within an accurate time frame. Also provided is an overview of the claims reconsideration appeals process with the steps and appropriate documentation needed for review and determination.

Cultural Competency and Linguistic Requirements and Services

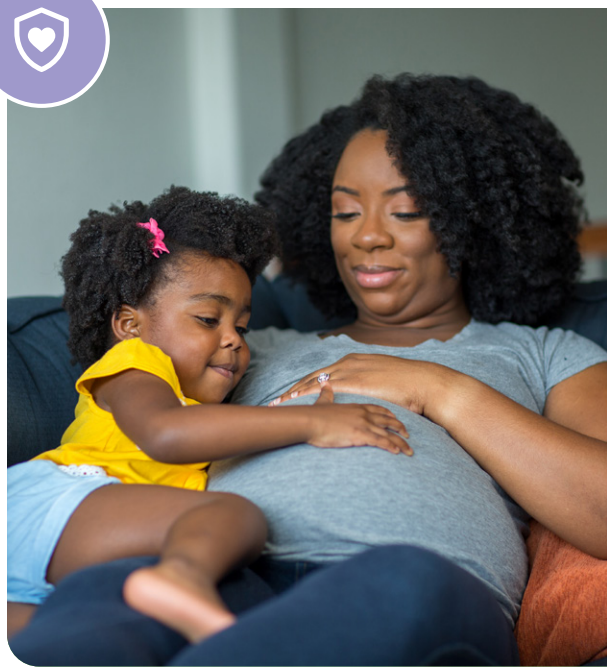
During this course you'll learn how to access our clinical programs and resources for patients, including:

- Identification and appropriate referral for mental health
- Drug and alcohol and substance abuse services
- Sensitivity training on diverse and special needs populations such as persons who are deaf or hard of hearing
- How to obtain sign language interpreters and how to work effectively with sign language interpreters.
- Cultural competency and treating special needs populations, including the right to treatment for individuals with disabilities.

Complaints, Grievances and Medical Necessity Reviews

Part 1 of this course offers information to providers regarding the Medicaid and CHIP member complaint and grievance process and how providers can submit complaint and grievance requests to HPP on behalf of their patients who are HPP members. Part 2 of this course offers information to providers regarding the Medicaid and CHIP member utilization management authorization request process, the need to provide supporting clinical documentation and orders required for a medical necessity review.

March of Dimes Training Opportunity: Breaking Through Bias in Maternity Care



Implicit bias refers to the attitudes and stereotypes that affect an individual's understanding, actions and decisions in an unconscious manner. At HPP, we strive to improve health outcomes for moms and babies, but to do that, we must address health threats such as implicit bias. March of Dimes offers implicit bias training called "Breaking Through Bias in Maternity Care" for providers to increase awareness and stimulate action to address implicit bias in maternity care.

This training will focus on the following four areas:

1. Overview of implicit bias and personal assessment

2. Historical overview of structural racism in the U.S.

3. Strategies to mitigate racial bias in maternity care

4. Building a culture of equity within an organization

Participants have the option of joining a live, in-person group training or participating in a one-hour online version. Training is an important step in helping provide health care providers with the insights they need to recognize and address implicit bias, ultimately helping organizations reach a broader goal of achieving health equity for moms and babies.

For more information and to sign up, visit www.marchofdimes.org/implicitbias.

Completing Developmental Screenings

According to the American Academy of Pediatrics, standardized developmental screenings should be conducted during 9-month, 18-month and 30-month well-child visits. In addition, physicians should administer a screening for autism spectrum disorder during the 18- and 24-month health supervision visits. Developmental screenings should be completed for all patients with a confirmed elevated blood lead level (BLL)—even if a screening was completed during a previous well-child visit.

As providers, you must document all surveillance, screening and referral activities. You must also include a copy of the validated developmental or autism screening tool used to conduct the screening. If you suspect that a child may have a potential developmental delay and require early intervention services, a referral should be made to CONNECT via phone (1-800-692-7288) or email (connecthelp@tiu11.org). You may use any validated screening tool to perform this preventive service. Please see references/resources below:

- Provider Notice
- MA Bulletin 99-09-07 (Structured Screening)
- Validated Screening Tools

The Integrated Care Plan Program

The Integrated Care Plan (ICP) program is a pay-for-performance incentive implemented by the Department of Human Services (DHS) for Medicaid recipients. The initiative encourages stronger collaboration between the physical health and behavioral health managed care organizations (BH-MCO). *As a reminder, certain information and diagnoses that pertain to mental illness must follow all state and federal mandates for protection, sharing and consent.*

The ICP program focuses on members who are diagnosed with severe and persistent mental illnesses – commonly referred to as SPMI. The diagnoses that the State includes into this category include:

- Schizophrenia
- Schizoaffective Disorder
- Manic Episode
- Major Depressive Disorder - Single Episode
- Major Depressive Disorder – Recurrent
- Unspecified Psychosis (not due to a substance or known physiological condition)
- Borderline Personality Disorder

If a member has a claim through either the physical or behavioral health plan for one or more of the diagnoses within the past two years, they are classified as having an SPMI diagnosis.

There are several components of the initiative that need to be completed. Care Managers must collaborate with the BH-MCO to complete an ICP (or Member Details for members with an SPMI diagnosis). Each year, the State determines how many care plans each Managed Care Organization needs to complete. For 2021, a total of 1,200 ICPs need to be completed. In addition, in 2021, DHS is also encouraging increased coordination with providers, meaning that when ICPs are created, they will also be shared with the member's primary care practice site.

The following eight performance measures also contribute to the ICP program:

- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
- Combined BH-PH Inpatient 30 Day Readmission Rate for Individuals with Serious Persistent Mental Illness (SPMI)
- Emergency Department Utilization for Individuals with Serious Persistent Mental Illness (SPMI)
- Combined BH-PH Inpatient Admission Utilization for Individuals with Serious Persistent Mental Illness (SPMI)
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications (SSD)
- Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)
- Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9/0%) (HPCMI)

Coming soon!

Health Partners (Medicaid) and Community Behavioral Health will be hosting a joint webinar to review the ICP program in further detail this fall! Stay tuned for more details.

HPP's Clinical Programs can help members with serious mental illness and comorbidities and/or significant barriers to treatment.
Please call 215-845-4797, 8 a.m. to 4:30 p.m., Monday through Friday to refer members who need assistance.

Validating Your Provider Data

The Centers for Medicare and Medicaid Services (CMS) requires all Medicare Advantage plans to validate their provider data on a quarterly basis. The regulation ensures that our members can access health care services without encountering barriers (e.g., making sure that office addresses, patient hours, practitioner names and panel status are correct) and requires you to work with us each quarter to validate the provider data we have on file.

Process For Health Partners Plans - How To Validate Your Profile

You can find your provider data validation forms on NaviNet. To access your profile please follow the below steps:

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.

Your office is <u>required to validate</u> the information listed on the provider profile. Please respond to this request even if your data is correct.

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

The profile is separated into two sections:

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

Please thoroughly review both sections of the profile. Be sure to check the appropriate box on the cover sheet to clearly indicate whether or not you have changes, then sign and date before returning it to Health Partners Plans. It is critical that we receive a response from you attesting that changes are required, or that the information presented is accurate therefore no changes are required.

If you are personally unable to validate and/or correct the data included on this profile, please ask others within your organization to complete a full validation of the data.

Where to Send Your Validated Profile

Validated profiles should be sent to datavalidation@hpplans.com. If you choose to email the profiles back to us, please use the following subject line: "Provider Profile Validation Response – XX-XXXXXXX" (X – represents your TIN). You can also fax your profile to (267) 515-6650. Once we receive your profile, we will review it and make corrections or suggestions. If anything is unclear, we will contact you for clarification.

If you have more than 25 providers in your organization and would like HPP to conduct a comparison of your data to our current data instead of the provider profile approach, please email us at the address listed above and we will provide specific roster file specifications.

Any use of rosters will be implemented in subsequent quarterly data validations cycles.

We appreciate your prompt attention to this request. Your cooperation in this ongoing process will ensure that our members have access to accurate information about your practice, which will help them make informed decisions about their care.

Expanding Access to Care with Telehealth

HPP encourages providers to utilize telehealth when appropriate to improve and expand patient access to care. Professional telehealth services are covered and are reimbursable when the following requirements are met:

- Service is medically necessary and is delivered using:
  - Interactive, synchronous (real-time) two-way audio and video
  - A telephone (audio telecommunication only/telephone call)
  - Online digital communication.
- Interaction must occur between provider and member.
- Service must be rendered by HPP Physician (PCP or specialist), CRNP, nutritionist, registered nurse or physician assistant working under the direct supervision of the physician contracted to perform professional telehealth services.

Why should HPP providers consider using telehealth?

- Reduces patient barrier to accessing timely care for non-emergent or routine care
- Increases patient ability to access primary care, specialists and behavioral health visits for chronic conditions and medication management
- Improves provider ability to monitor clinical signs for certain chronic medical conditions (e.g., blood pressure, blood glucose, weight gain)
- Increases patient compliance with necessary hospitalization follow up visits
- Improves provider no-show rates
- And, it is a covered reimbursable service!

Advance Care Planning

Have you discussed the importance of Advance Care Planning (ACP) with your patients? Initiating a conversation about ACP during a wellness visit helps support patient autonomy, facilitates decision making and ensures better care at the end of life.

Voluntary ACP is a face-to-face service between the physician (or other qualified health care professional) and the patient. During this service, the physician and the patient discuss advance directives with or without completing relevant legal forms. Examples of advance directives include:

- Living wills
- Instruction directives
- Health care proxy
- Health care power of attorney

Medicare pays for ACP, so you may be reimbursed for ACP services. Please discuss CPT codes with your HPP Network Account Manager (NAM).

Fall Risk Assessment and Counseling

According to the CDC, 1 in 4 older adults in America will have a fall, making fall prevention a public health concern. As a provider, please remember to screen your patients for fall risks and counsel them on ways to prevent falls. Certain drugs can be a contributing factor to falls, so it is important to make medication review part of fall prevention screenings. You can also offer simple tips to help patients prevent falls such as:

- Removing hazards like loose area rugs from living spaces
- Wearing slip-resistant shoes
- Maintaining an active lifestyle to keep muscles and joints flexible and limber

Sources:

https://www.who.int/news-room/fact-sheets/detail/falls

https://www.cdc.gov/steadi/index.html

Pediatric Updates

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

The Centers for Disease Control and Prevention (CDC) and the United States Preventive Services Task Force (USPSTF) are now recommending expanded screening of hepatitis C virus (HCV) for all individuals between 18 and 79 years of age. Although there are no coding changes reflected with this update, the American Academy of Pediatrics' (AAP) 2021 Periodicity Schedule has been revised with two updates:

- Risk assessment for HCV infection has been added to occur at the ages of 18, 19, and 20 years old, with appropriate action to follow, if positive.
- Footnote 22 has been added to read as follows: "*Those at increased risk of HCV infection, including those with past or current injection drug use, should be tested for HCV infection and reassessed annually.*"

Effective March 1, 2021, any applicable referral codes, modifiers and diagnosis codes to the EPSDT Program as it relates to billing, can be found at the following link:

https://www.dhs.pa.gov/providers/PROMISe_Guides/Pages/PROMISe-Handbooks.aspx.

Childhood and Adolescent Immunizations

The Department of Human Services (DHS) has updated the immunization schedule for children and adolescents aged 18 or younger. This bulletin includes the 2021 Immunization schedule, which is separated into 3 main sections and contains corresponding notes on the following topics:

Recommended child and adolescent immunization schedule for ages 18 years or younger, United States, 2021 (Table 1)

Recommended catch-up immunization schedule for children and adolescents who start late or who are more than one month behind, United States, 2021 (Table 2)

Recommended child and adolescent immunization schedule by medical indication, United States, 2021 (Table 3)

Updates are included in the below links:

http://www.cdc.gov/vaccines/hcp/vis/index.html

https://www.cdc.gov/vaccines/schedules/index.html

COVID-19 Vaccine Reimbursements for Providers

Beginning June 8, 2021, CMS will now reimburse providers an additional add-on payment of $35.00 for COVID-19 vaccinations administered to beneficiaries in their homes. The add-on payment of $35.00 will be made in addition to the base COVID-19 vaccine administration payment of $40.00, raising the total provider reimbursement to approximately $75.00 when these services are provided to patients in their homes.

To facilitate this add-on payment, CMS has established a new HCPCS code, M0201, to report when COVID-19 vaccines are administered to patients in their homes.

Codes for Administering the Vaccine in the Patient's Home

Use HCPCS Level II code M0201 for the additional payment for administering the COVID-19 vaccine to certain Medicare patients in their homes.

- You should report this code in addition to the appropriate CPT code for the product- and dose-specific COVID-19 vaccine administration.
- You can only report the HCPCS Level II code for home vaccine administration once per home per date of service.
- If you administer the COVID-19 vaccine to more than one Medicare patient in a single home on the same day, you should:
  - Only report the HCPCS Level II code M0201 once
  - Report the appropriate CPT code for the product- and dose-specific COVID-19 vaccine administration for each Medicare patient vaccinated in the home that day

Sources:

https://www.cms.gov/medicare/covid-19/coding-covid-19-vaccine-shots

Postpartum Home Services

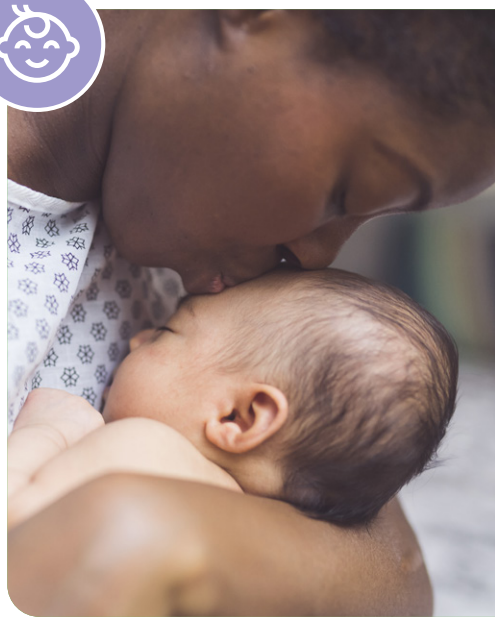
HPP offers several different home services for moms when they first come home with a new baby. The services offered by HPP include:

Mom/Baby Visits

The mom and baby are visited by a registered nurse, ideally within a week of the birth. These visits are primarily clinical, including limited physical examination. They are usually arranged prior to discharge from the birth admission. The nurse sends notes to the OB provider and may also call the Baby Partners care coordinator for any concerns.

Postpartum Clinical Visit

We always encourage our members to visit their OB provider for their postpartum checkup between 10 and 84 days after the birth, but some women may be unable or unwilling to complete this appointment. Baby Partners can arrange a clinical postpartum home visit with a nurse practitioner. The visit includes assessment of mom's and baby's vital signs and adjustment and limited physical examination. This visit meets HEDIS criteria for the postpartum visit.



Maternity Home Visiting Program

All HPP families are encouraged to enroll in our maternity home visiting program. Members receive at least two home visits (all home visits are virtual at present) from a nurse or social worker. These visits focus on parenting resources, developmental milestones, SDoH needs assessments and appropriate referrals to resources, including referrals for ongoing services if needed. Members are referred to the program by their care coordinator. Providers can also refer members to this program by sending an email with member data and contact information to BPatHome@phmc.org. HPP collaborates with the Nurse-Family Partnership, the Maternity Care Coalition and other programs as part of the maternity home visiting program.

Adult Dental Benefits

The top two reasons adults give for not going to the dentist are the cost and the belief that they already have a healthy mouth with no dental needs. Because oral health status has been linked to cardiovascular disease, pregnancy complications, diabetes and other medical conditions, it is universally known by health care providers that patients need to see the dentist for preventive care even if they feel healthy. But did you know that Health Partners (Medicaid) members have the following dental services covered for $0*?

- Diagnostic exams and preventative prophylaxis cleanings every six months
- Radiographs
- Dental emergency exams
- Dentures
- Fillings
- Extractions

*Some services require prior authorization; refer to the provider manual for more details

People who are unaware of the availability of dental benefits may utilize the hospital emergency room to seek care for unexpected dental problems. If you see a patient for an emergency room follow up due to dental problems, encourage them to see the dentist for definitive treatment.

Educating your patients on the importance of regular dental visits and helping them understand that they have comprehensive dental benefits available is an important step to lowering the barriers to help them achieve optimal oral health.

Prevention Corner

Keep your patients safe by encouraging colorectal cancer screening

Colorectal Cancer (CRC) is the third most commonly diagnosed cancer in men and women. However, the death rate has dropped over the past several decades, largely because of higher rates of screening. Therefore, CRC screening is critical to achieve positive patient outcomes and promote quality care.

We know many people are hesitant to get a colonoscopy because they don't have the time, don't like the prep or are scared.

If you have patients who are not interested in a colonoscopy or flex sigmoidoscopy, you can educate them about colorectal screening and offer alternative tests that are non-invasive, such as a FOBT or FIT-DNA test. These home tests can be obtained by writing a script. The member can pick up the home test kit at a Quest Lab.

Support Colorectal Cancer Screening for your patients who are 50-75 years of age by ordering one of the following preventive tests:

- Fecal occult blood test (FOBT)
- FIT-DNA test
- Flexible sigmoidoscopy
- CT Colonography
- Colonoscopy

Required training reminders

Model of Care - Dual-Eligible Special Needs Plan (D-SNP) **Provider Training**

If you are a provider who has one or more Health Partners Medicare Special D-SNP members assigned to your practice, at least one person on your staff who is involved in the care of the D-SNP members must complete our annual D-SNP Model of Care training module. This training is required by the Centers for Medicare & Medicaid Services (CMS).

The training course is available through our online HPP University at 2021 Model of Care Training. The course will take approximately 10 minutes to complete. Please complete by October 31, 2021.

Virtual Career Day
with Health Partners Plans

HPP Virtual Career Day and Professional Development Workshops

On October 20, HPP will host a virtual career day event via Zoom. Job seekers will be able to connect, network and discuss open positions with employers. HPP is partnering with Impact Services to bring in employers. This event is open to HPP members and the community, so we encourage you to spread the word!

The virtual career day will expose attendees to a variety of career and job opportunities by connecting them with business partners, providing a realistic picture of the workplace and helping to make the connection between their community and the workplace.

Date: Oct 20, 2021

Time: 10 a.m.- 12:30 p.m.

Location: Zoom https://us02web.zoom.us/j/88901190282 or Meeting ID: 889 0119 0282

Participants can register in advance via the Zoom link above.

HPP will also host a series of virtual professional development workshops leading up to the event for people who want to update their resume, learn about effective communication and brush up on their interviewing skills before the event.

These workshops will take place every Wednesday from September 22 through October 13 from 1-2 p.m. Participants can register for the workshops in advance here: www.hpplans.com/wellnesspartners.

If you or your patients have questions about these events, please email wellnesspartners@hpplans.com or call 215-967-4515 (Monday – Friday, 9 a.m. – 5 p.m.)

What is the Health Outcomes Survey (HOS)?

- The HOS is scheduled to start this August and run through November. Every year, a random selection of Medicare members from each participating MA plan are asked to detail their interactions with their physicians as part of the HOS.
- A baseline survey is administered to a new Medicare member group each year and two years later, these same members are surveyed again to see if they have maintained or improved their physical and mental health. HOS also asks members about their risk of falling, bladder control concerns and overall physical activity
- The survey is important because it helps to evaluate how members view their current health status and determine if providers addressed their health concerns.

Sample HOS Survey Questions and Domains	Sample Provider Questions to Improve HOS Member Communication
Improving or Maintaining Physical Health Have you had any of the following problems with your work or other regular daily activities because of your physical health? During the past four weeks, has pain stopped you from doing things you want to do?	**Improving or Maintaining Physical Health** Your physical health affects your ability to get around and live independently. Does your health stop you from doing your daily activities?
Improving or Maintaining Mental Health Have you had any of the following problems with your work or other regular daily activities because of emotional health? Have you had a lack of energy or felt sad or depressed most days?	**Improving or Maintaining Mental Health** We talk about your physical health a lot, but we should also talk about your mental health. Does your mental health affect your ability to complete your daily activities? As an HPP member, you have direct access to your Magellan behavioral health provider (Phone #:1-800-424-3704).
Monitoring Physical Activity In the past 12 months, did a doctor or other health care provider advise you to start, increase or maintain your level of exercise or physical activity?	**Monitoring Physical Activity** Remaining physically active is still important to your health. If you can, do you try to walk more or do some type of light exercise?
Improving Bladder Control Have you ever talked with a doctor, nurse or other health care provider about leaking of urine? Have you ever talked with a doctor, nurse or other health care provider about any of these approaches: bladder training, exercises, medication, surgery?	**Improving Bladder Control** Physical activity can also help with other health concerns like bladder leakage, also known as urinary incontinence. I don't want you to feel embarrassed, but it is an important health topic. Have you ever had any urinary leakage? If so, it can be treated, and I can refer you to a specialist if necessary.
Reducing the Risk of Falling Did you fall in the past 12 months? In the past 12 months, did a doctor or other health care provider talk with you about falling or problems with balance or walking?	**Fall Prevention** Accidental falls can be dangerous, but there are ways to reduce the risk of a fall. Have you fallen since your last visit, or had any changes to your walking or balance?

Recommended HOS Strategies

- You can help improve your patient's health and HOS measures by discussing these measures at the patient's annual wellness visit.
- Please consider incorporating HOS-like questions in your initial and ongoing health assessments to help promote and enhance patient-provider interactions that can result in improved communication and quality of life.
- HPP encourages providers to use a checklist (an HPP resource available via your NAM) to improve communication with patients and enhance patient-provider interactions.
- Thank you for your continued commitment to your patients. Your daily dedication is key to keeping patients healthier, happier and more engaged with improving their health outcomes.

SNAP for Older Adults

Do you have an older patient who may be food insecure? Studies have shown that older adults who are food insecure have:

- Diets that are less nutritious
- Worse health outcomes
- A higher risk of depression

In contrast, seniors enrolled in The Supplemental Nutrition Assistance Program (SNAP) are healthier, hospitalized less and less likely to go to a nursing home.

SNAP helps eligible individuals and families in Pennsylvania increase purchasing power at the grocery store, giving them access to more nutritious foods. Benefits are provided monthly through an Electronic Benefit Transfer (EBT) card, which recipients use to purchase foods at their local grocery stores and farmers markets. These benefits are not cash and can only be used on food purchases.

SNAP eligibility is based on factors such as household income, housing costs and medical expenses. An older adult can bring in more than $2,000 a month and still qualify. For a senior couple, that increases to more than $2,700. Income requirements change each year.

If you have an older adult who may be eligible for SNAP, please encourage them to apply by going to the State website at: DHS.PA.Gov or by calling 1-877-395-8930 for assistance.

Facility Location Requirement for Professional Claims

When submitting professional claims for services rendered with place of service 19, 21, 22, 23, 24, 31 or 32, it is mandatory to include the service facility segment (2310C).

The segment must include the NPI of service facility.

Referring Provider Requirements

A referring provider segment (2310A) is required for certain provider types. Home health, hospice, certified nutritionists, DME, laboratory, x-ray clinic and renal dialysis providers must include this segment when submitting claims.

The Importance of Completing the Social Determinants of Health Assessment

Recently, there has been a greater awareness of social determinants of health (SDoH). SDoH are the conditions in which people are born, grow, work, live and age. SDoH include societal and environmental conditions such as housing, food, education, transportation, violence, social support, employment and health behaviors.

We want to stress the importance of completing an annual SDoH assessment on your patients. Completing an assessment allows you to identify barriers and provide support for your patients in areas where support is needed. Identified barriers should be addressed by referral to appropriate community resources, revisited during subsequent visits and continuously billed to HPP using appropriate codes.

HPP is committed to addressing members' SDoH needs, as well. Our care coordinators and Member Relations representatives utilize Aunt Bertha, an online directory of local resources and support organizations, to help members find the resources they need.

You can refer any of your patients for care coordination support by calling our Clinical Connections team at 215-845-4797. We will reach out to these members for the appropriate programs.

If you have any questions about SDoH, please connect with your Network Account Manager (NAM).

Reminder: Complete Your Medicare Compliance Attestation

In May 2021, HPP mailed our annual Medicare Provider Compliance Attestation reminder notices to our Medicare providers. As in previous years, the attestations were due within 30 days of the notification receipt date. If your organization has not yet completed the Medicare Provider Compliance Attestation, we respectfully request that you complete the attestation online at hpplans.com/providerattestation.

Please note the following regarding HPP's Medicare Provider Compliance Attestation requirements:

- Only one attestation needs to be submitted annually for provider offices or groups with multiple entities. New providers that are affiliated with a provider group currently contracted with HPP do not need to submit the attestation.
- Completed 2020 attestations do not fulfill the 2021 attestation requirement; new attestations must be submitted for 2021. Providers who fail to complete this annual requirement may be subjected to completing a process improvement plan.
- This attestation is unique to HPP Medicare and completing it does not satisfy your obligations with other health plans. Likewise, attestations that your organization submits to other health plans do not satisfy your obligations with HPP.

Your completed provider compliance attestation form will be submitted to a secure, routinely monitored email address.

For more information and resources regarding HPP's compliance program requirements for HPP Medicare providers, please see Chapter 13 of our provider manual, located online at hpplans.com/providermanual.

If you have any questions, contact your Network Account Manager (NAM) 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.