PERENNIAL ADVANTAGE

Provider Newsletter

December 2022

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Quality Measurement and Performance Improvement

The Quality Improvement Program (QI Program) takes a proactive approach to assure and improve the way we provide care and engage with our members, partners, and other stakeholders so that we may fully realize our vision, mission, and commitment to member care.

The QI Program includes:

- Monitoring of medical care
- Patient safety
- Behavioral health services
- Delivery of services to members

QI Program effectiveness is assessed annually and reviewed by the Quality Improvement Committee (QIC), and program enhancements are made accordingly. As our valued partner, we look forward to communicating QI program initiatives to you in the upcoming months.

Star Ratings

The Centers for Medicare and Medicaid Services (CMS) publishes Medicare Advantage (MA) Star Ratings yearly to measure MA health plan performance. An important component of the Star Ratings effort is to provide Medicare enrollees and their caregivers with meaningful information about health care costs and the quality of benefits available to them.

MA plans are rated on a scale of 1 to 5 stars–with 5 being the highest—based on how well the plan performs in the following areas:

- Helping members stay healthy
- Managing chronic conditions
- Member experience with the plan
- Member complaints
- The plan's customer service

Information On Star Ratings

Five-star rated health plans have more exposure to potential enrollees, which in turn can help plan providers grow their practices. Help us improve member experience by ensuring that you and your office staff are not only following plan standards but also treating members in a way that shows how much you and our plan care about their health and well-being.

CMS adopted several changes to the 2022 Star Ratings to address the impact of the 2019 Coronavirus and expected changes in plan performance.

For more information on Star Ratings, visit the most recent technical notes at: **www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html**

You may also reference the 2022 Star Ratings fact sheet at: **www.cms.gov/files/document/2022-star-ratings-fact-sheet1082021.pdf**

CCIP

Chronic Care Improvement Program

The goal of the CCIP (Chronic Care Improvement Program) is to support continuous improvement of the quality of services provided to plan members with specific chronic diagnoses. The CCIP addresses the unique characteristic and needs of a targeted population, promotes effective management of chronic diseases, and improves care and health outcomes. The CCIP is conducted over a three-year period and includes interventions such as:

- Engaging members to be partners in their care
- Increasing disease management and preventive services utilization
- Improving health outcomes by facilitating development of targeted goals and producing best practices

The formulation of this program begins with a comprehensive analysis of the members with the targeted chronic diagnosis. Once the framework is defined, plan and provider key staff are educated on the implementation of the CCIP as well as the process that needs to be followed by both the Clinical Education and Quality Improvements teams.

As a plan provider, you play an important role in helping to reduce chronic conditions and helping members engage in their care. Visit the plan website to learn more about our CCIP efforts and target conditions.

Clinical Practice Guidelines

The CPG (Clinical Practice Guidelines) and PHG (Preventive Health Guidelines) are nationally recognized sources put in place to support the adoption and oversight of clinical practices as well as preventive health guidelines. The guidelines are updated yearly as new technology or scientific findings change and are approved by the plan's Credentialing Committee and Clinical Peer Committee.

We encourage you to reference the guidelines posted on the provider website when treating patients with chronic conditions such as:

- COPD
- Dementia
- Depression
- Diabetes
- Heart Failure
- Hypertension

The guidelines are intended to support our health care team and serve as resources to ensure our providers have the most up to date, evidence-based information recommended by nationally recognized organizations. Visit the plan website to view the full listing of guidelines.

Potential Quality Issues

Potential quality issue (PQI) is defined as a possible adverse variation from expected provider performance, clinical care, or outcome of care that needs additional review. Examples of potential quality issues include but are not limited to:

- Falls with injury/additional treatment required
- Medication errors with injury/additional treatment required
- Incidents resulting in death
- Incidents resulting in severe brain or spinal damage to a patient
- Surgical procedures performed on the wrong patient
- Surgical procedures unrelated to the patient's diagnosis or medical needs

Ensure to report all PQIs as soon as possible by sending a secure email to **pqireferral@allyalign.com** We can help to review the PQI and determine if a change in procedure is required to prevent further incidences.

Appeals

Members, designated member representatives, and plan providers have the right to ask us, the plan, to change a decision for a denied service or claim.

Appeal Timeframes

Pre-service requests are processed as soon as possible but no later than thirty (30) calendar days for standard appeals or 72 hours for expedited appeals (unless a 14-day extension is requested).

Post-service requests are processed within sixty (60) calendar days of receipt.

When submitting a request, ensure to include the following information to help us make a timely determination:

- An appeal letter, including:
  - ✓ Member Name and Plan Member ID
  - ✓ Provider Name and Provider NPI
  - ✓ Date of Service
  - ✓ The reasons why you disagree with the plan's decision (NCD, LCD, Medical Criteria, Benefit policy)
- A copy of the denial letter or Explanation of Benefits letter
- Documents that support your position (for example, medical records and office notes or prior authorization letter)

Appeals received are reviewed on a case-by-case basis. Therefore, it is important that you notify the member when submitting an appeal on their behalf, or when recommending a member to submit an appeal, that we, the plan, have the ultimate responsibility of making coverage determinations based on plan guidelines. Accordingly, only the plans' Medical Director may render an adverse determination based on medical necessity.

Grievances

A grievance is any complaint or dispute (other than an organization determination) submitted by a plan member, or their designated representative, expressing dissatisfaction with any of the following:

- Health plan operations
- Health plan activities
- Health plan behavior
- Health plan provider network

Grievances are recorded and tracked regardless of whether remedial action is requested or necessary. Grievances can be filed within sixty (60) calendar days of the occurrence date.

Grievance Timeframes:

Grievances are processed as soon as possible but no later than thirty (30) calendar days for standard or 24 hours for expedited grievances (unless a 14-day extension is requested).

Important things you should know as a contracted provider:

- CMS requires all grievances to be reviewed and closed within thirty (30) calendar days of received date. Therefore, if you receive a plan request for medical records, we urge that you provide the requested information as soon as possible to ensure timely grievance resolution.
- Grievances are based on the patients' observations of the treatment they experienced
- All quality-of-care grievances are reviewed by the plan's Quality Department and are kept confidential.

If a grievance is received concerning your provider practice, a plan representative will contact you for details and necessary remedial actions.

Model of Care
Special Needs Plans

A special needs plan (SNP) is a Medicare Advantage (MA) plan specifically designed to provide targeted care and limit enrollment to special needs individuals.

The SNP Model of Care (MOC)

The SNP MOC is a detailed, written commitment we (as the plan) make to CMS on how we provide care to enrolled members.

The key sections to the SNP MOC are:

- Description of the SNP population
- Care coordination
- Health Risk Assessment Tool (HRAT)
- The Individualized Care Plan (ICP)
- The Interdisciplinary Care Team (ICT)
- Care transition protocol
- Provider network
- Quality measurement and performance improvement

Yearly SNP Model of Care Training

CMS requires initial and annual SNP MOC training for all Special Needs Plan employed and contracted staff that support the SNP population. This requirement extends to all in-network and out-of-network providers who provide care to SNP beneficiaries on a routine basis.

As a participating SNP plan provider, you must complete the SNP MOC training annually. To review the training, click here to visit the Model of Care Training section of the provider website.

Provider Participation Standards

Provider Manual

Providers are encouraged to reference the Provider Manual (located within the Provider Documents folder) on an ongoing basis for plan-specific information. This manual includes information such as:

- Key contacts
- Eligibility
- Benefits
- Referrals
- Billing/Claims
- Credentialing
- Quality improvement
- Provider participation standards

As a participating plan provider, it is important that you are aware of the plan participation standards that follow. Full details on each standard are included in the provider manual.

Dual Eligibles and Cost-Sharing

Providers should not hold patients who are eligible for both Medicare and Medicaid benefits liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. For dual eligible patients, providers should accept the plan payment as payment in full or should bill the appropriate State source.

Anti-Discrimination

As a participating plan provider, you and your office staff must provide services to all plan customers, consistent with the benefits covered in their policy, without regard to race, ethnicity, national origin, religion, sexual orientation, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, claims experience, medical history, evidence of insurability, genetic information, source of payment, or any other bases deemed unlawful under federal, state, or local law.

It is important that you and your staff provide covered services in a culturally competent manner and ensure those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities receive the health care to which they are entitled.

Member Rights and Responsibilities

The following rights and responsibilities apply to plan members and are to be protected:

- ✓ The right to be treated with dignity and respect
- ✓ The right to see participating providers, get covered services. and get prescriptions filled promptly
- ✓ The right to know about treatment choices and obtain medical advice from providers that is in their best interest regardless of plan rules. To ensure this right, the plan does not interfere with the provider's medical advice to patients.
- ✓ The right to participate in decisions about their healthcare
- ✓ The right to make complaints
- ✓ The right to receive complete and accurate health information
- ✓ The right to confidentiality of their healthcare information
- ✓ The right to privacy, respect, consideration, and dignity
- ✓ The right to refuse to participate in research
- ✓ The right to interpretive services, as necessary
- ✓ The right to change providers
- ✓ The right to request provider malpractice insurance coverage and validate the credentials of health care professionals

Members have the following responsibilities:

- Becoming familiar with plan coverage and rules they must follow to obtain care from network providers
- Knowing which providers are part of the plan network
- Notifying providers about their enrollment with the plan and presenting their member card when accessing care
- Providing providers with the information needed to properly receive their care
- Paying plan premiums and any copayments they may have for covered services
- Informing the provider and the plan if they have any questions or concerns regarding their coverage, services or rights and responsibilities
- Notifying the plan if they have address or phone number changes

Medical Record Documentation

Good quality medical records are an essential component of safe and effective healthcare. Patient records should include:

- History/physical, clinical findings, impressions, and diagnosis
- Lab, x-rays, and studies
- Medications, including over-the-counter products and dietary supplements
- Advanced directives
- Medical advice given in person or over the phone, including medical advice provided by after-hours information or triage services
- Consistent entries ensure that diagnosis and treatment align with the initial assessment and follow-up care.

Access Availability Standards

To ensure plan members have access to care when they need it, the plan has established written access and availability standards for participating providers which cover routine, urgent, preventative, and emergent services. Access standards are available in the provider manual and are required to be met for continued plan participation. The Access and Availability survey is used to review provider compliance with access standards. The survey is sent to providers yearly. We encourage you to participate in the survey when distributed.

Safe and Sanitary Environments for Members

Provider sites are expected to comply with nationally recognized standards of safe and sanitary environments such as those of the CDC. Those standards should include:

- Having an infection control program
- Safeguards to prevent medication errors
- Fall and injury prevention procedures
- Proper management of potential threats and hazards
- By providing a safe and sanitary environment, you can avoid member grievances and potential liabilities.

Advanced Directives

The Federal Patient Self-Determination Act ensures the patient's right to participate in healthcare decision-making, including decisions about withholding resuscitative services or declining/withdrawing life sustaining treatment. Participating providers may not condition the provision of care or otherwise discriminate against an individual based on whether the individual has executed an advance directive. At the time a service is provided, the provider should ask the member to provide a copy of the advance directive to be included in his/her medical record. If you cannot as a matter of conscience fulfill the member's written advance directive, you must advise the member and the plan. Upon notice, the plan, with your assistance, will arrange for a transfer of care.

Marketing Activities in a Healthcare Setting

The provider manual includes genera guidelines to assist plan providers in determining what marketing and patient outreach activities are permissible under the CMS guidelines. CMS has advised Medicare Advantage plans to prohibit providers from steering or attempting to steer an undecided potential enrollee toward a specific plan or limiting to several plans offered either by the plan sponsor or another sponsor based on the financial interest of the provider or agent. Providers should remain neutral parties to the extent they assist beneficiaries with enrollment decisions. Please consult the provider manual for a full list of guidelines on provider marketing activities. By providing a safe and sanitary environment, you can avoid member grievances and potential liabilities.

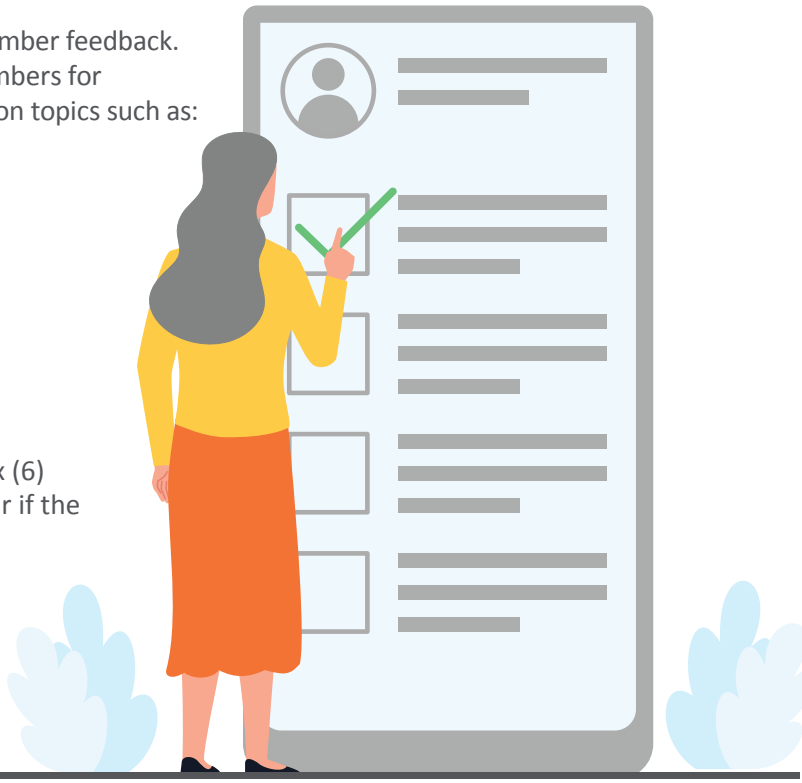
Member Satisfaction Survey

As we strive to improve healthcare for seniors, we encourage member feedback. A Member Satisfaction Survey is distributed annually to plan members for qualifying plans*. The survey asks members to provide feedback on topics such as:

- Provider network
- Plan services (customer service, claims processing/payment, benefits, etc.)
- Provider access and availability
- Member access to health care services

NOTE*: To ensure appropriate scoring, plan membership must include one hundred (100) members that have been enrolled six (6) months or more with the plan. The survey is skipped for the year if the plan membership does not meet this requirement.

Survey results are used to measure the effectiveness of our plan operations and identify new initiatives for improvement. The results are also shared with plan members and providers.



Provider Satisfaction Survey

The plan does not discriminate in terms of participation, reimbursement, or based on the population of beneficiaries serviced, against any health care professional who is acting within the scope of his or her license or certification under state law. We value our continued partnership and welcome your feedback.

Tell us how we are doing! A yearly provider satisfaction survey is posted on the provider website. We appreciate your feedback and incorporate survey results into our strategic initiatives.

Plan Provider Website

Access our website at: perennialadvantage.com/providers

When you're in need of additional information, be sure to utilize our provider website. Here you will find more information about the topics covered in this newsletter, as well as important information for members of your facility.

Make it Easy for Members to Find You

Maintaining complete and correct provider records in the Provider Directory is our priority as the directory provides an important source of provider information to our members. We encourage you to review your directory listing and notify us of any changes to your information as soon as possible, and no later than thirty (30) calendar days prior to an upcoming change.

Notify us of updates by emailing your plan network support representative or calling provider services. By providing this information promptly, you will ensure that members can reach you for needed care.

Contact Us

PERENNIAL ADVANTAGE

perennialadvantage.com/providers

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