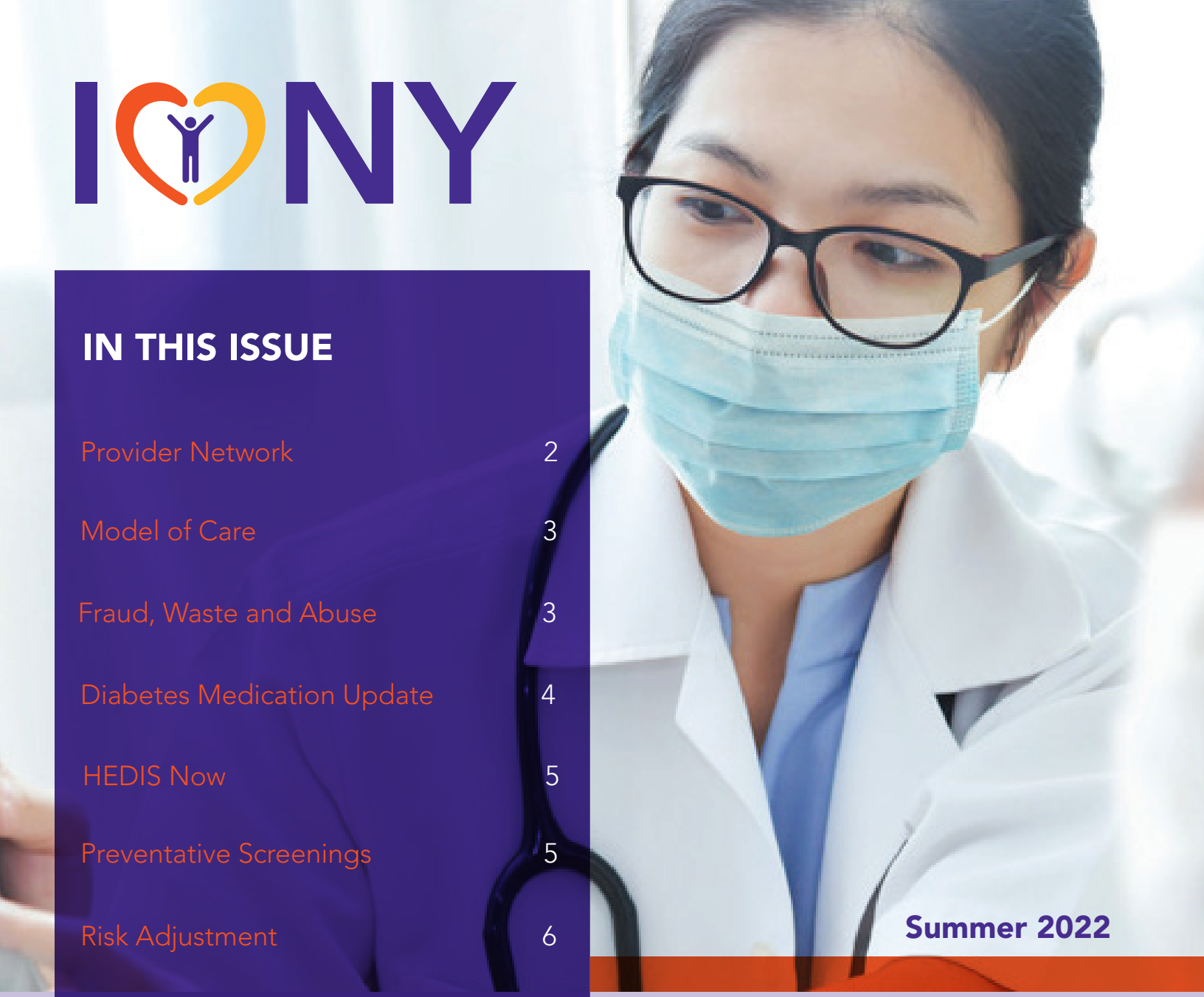
I ♥ NY



IN THIS ISSUE

Summer 2022

PROVIDER RESOURCES

Most provider resources can be found on the provider page of the CPHL 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!

Refer A Colleague!

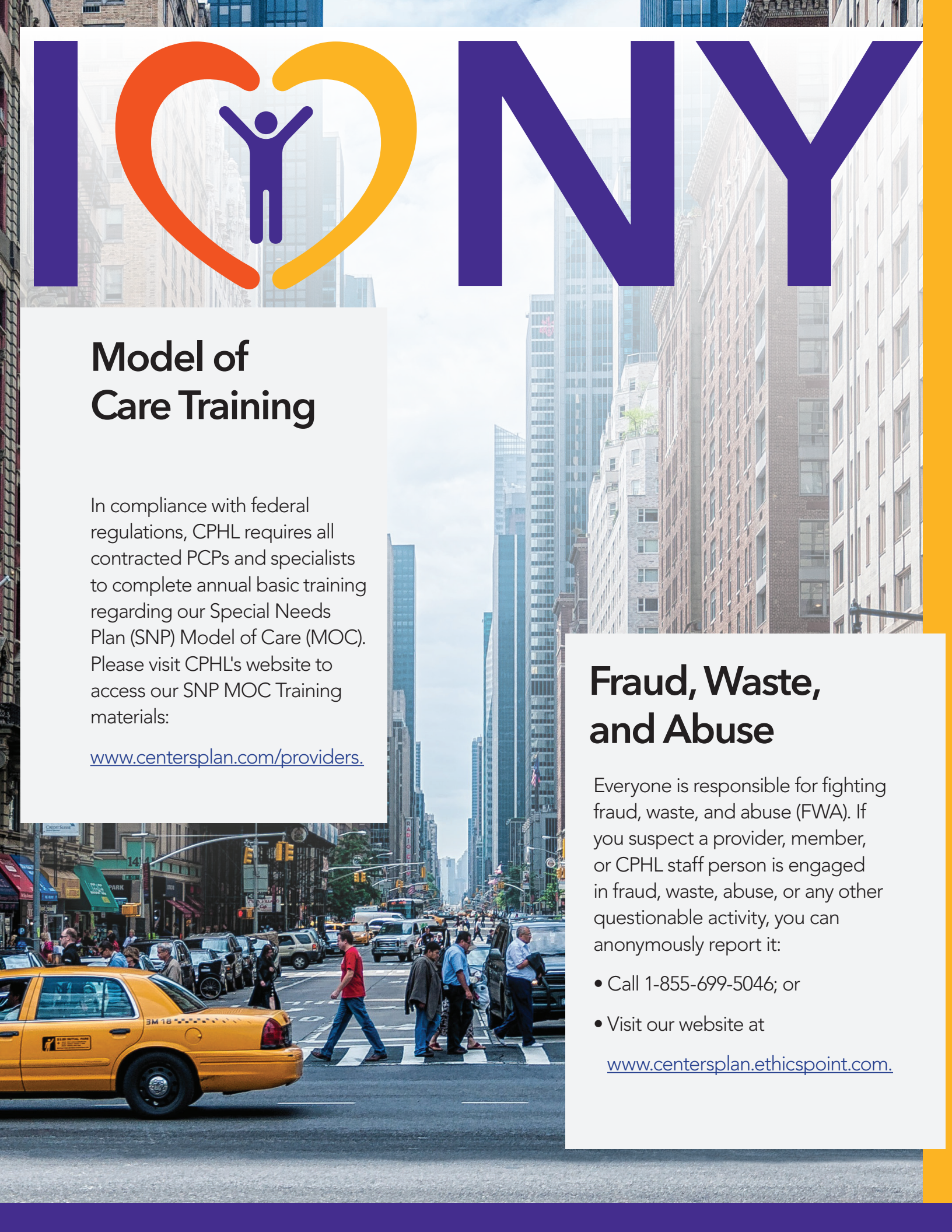
Have your colleagues join you, along with many other renowned providers, in working with the network that was built by New Yorkers for New Yorkers!

Call us at 917-789-5264, or scan the QR code below, for a simple and fast application to join our network!

Spread The Word!

Visit us at
www.centersplan.com/providerenrollment

A healthcare plan **built for New York.**



Model of Care Training

In compliance with federal regulations, CPHL requires all contracted PCPs and specialists to complete annual basic training regarding our Special Needs Plan (SNP) Model of Care (MOC). Please visit CPHL's 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 CPHL 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.

Diabetes Medication Formulary Update

2022 Medication Formulary Update: DDP-4 Inhibitors

The Centers Plan for Healthy Living Drug Formulary has several options for maintenance of glycemic control for patients diagnosed with type 2 diabetes. One of these options is a DDP-4 inhibitor. This class of medication blocks dipeptidyl peptidase 4 (DDP-4) enzyme enhancing incretin hormone activity – including glucagon-like peptide-1 (GLP-1) and glucose-dependent insulinotropic polypeptide (GIP). This increases insulin-release in a glucose dependent manner and decreases level

The 2022 Formulary has been updated, and the preferred formulary option is now Tradjenta.

	2021 Formulary	2022 Formulary
DDP-4 Inhibitor	Januvia 25 mg, 50 mg, 100 mg	Tradjenta 5 mg
DDP-4 Inhibitor/metformin	Janumet 50/500 mg, 50/1000 mg	Jentadueto 2.5/500 mg, 2.5/850 mg, 2.5/1000 mg
DDP-4 inhibitor/metformin XR	Janumet XR 50/500 mg, 50/1000 mg, 100/1000 mg	Jentadueto XR 2.5/1000 mg, 5/1000 mg

DDP-4 inhibitors are generally well tolerated. They have a low risk for hypoglycemia, are weight-neutral, and the expected % decrease in A1c is 0.5-0.7. Both sitagliptin and linagliptin are dosed once daily. Some clinical pearls are in the chart below:

	Adverse Effects	Renal Dosing
Januvia (Sitagliptin)	Arthralgia, bullous pemphigoid, GI distress, nasopharyngitis	GFR ≥45 ml/min – no dosage adjustment GFR ≥ 30 < 45 mL/min – 50 mg daily GFR <30 ml/min – 25 mg daily For patients on hemodialysis or peritoneal dialysis, 25 mg daily without regard to timing of hemodialysis
Tradjenta (Linagliptin)	Arthralgia, bullous pemphigoid, headache, nasopharyngitis, pancreatitis	**No renal dosage adjustment required**

The 2022 formulary also includes Glyxambi (empagliflozin/linagliptin) and Trijardy XR (empagliflozin/linagliptin/metformin), which is helpful for patients who prefer combination therapy to reduce pill burden.

In summary, there is no significant difference between Januvia's and Tradjenta's efficacy. However, an advantage of Tradjenta over Januvia is that renal dosage adjustment is not necessary for patients with altered kidney function. Since one of the complications of diabetes is a reduced kidney function, it is sometimes difficult to catch the kidney deterioration at the right moment and decrease the dose of Januvia as per the table above. Therefore, if one of your patients requires a DPP-4 inhibitor, we recommend to choose Tradjenta over Januvia.

Our goal is to continue providing our patients with optimal diabetic therapy and helping them reach their A1c target. Thank you for collaborating with us in this important endeavor!

HEDIS NOW

The HEDIS measure for Controlling High Blood Pressure (CBP) is designed to assess how well adults with hypertension are managing their condition. The CBP measure assesses patients aged 18 to 85 years, who had a diagnosis of hypertension (HTN), and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.

Hypertension has widespread health consequences, and continued monitoring of BP is important even when conducting telehealth visits. NCQA has revised the requirements for remote monitoring to **include readings taken by a patient with any digital device and reported to you during a telehealth visit.** (Readings taken by a patient using non-digital devices, such as manual blood pressure cuff and stethoscope, are still not accepted.)

When you are conducting telehealth visits with a hypertensive patient, please encourage them to use a digital BP cuff and report readings to you. If you are taking a patient's BP manually in the office, take care that the BP cuff size matches the arm of the patient. If white coat syndrome in the office setting may have raised the first BP reading to 140/90 mm Hg or greater, please take a second BP reading to help obtain the most accurate monitoring results.

Telehealth is a valuable resource when medically appropriate, and we appreciate your continuous monitoring and preventative care screenings. In addition to prescribing medications, you can help manage high BP by encouraging low-sodium diets, increased physical activity, and smoking cessation.

Colorectal Cancer Screenings:

The age guidelines for the Colorectal Cancer Screening measure were also updated in HEDIS Measurement Year 2022 to match updates to the US Preventive Services Task Force (USPSTF) guidelines.

The Colorectal Cancer Screening measure is now designed to **assess adults aged 45 to 75 years** who had appropriate screenings for colorectal cancer.

PREVENTATIVE SCREENINGS

Preventative screenings, like those for certain cancers, are critical for early detection and significant for prognosis and favorable outcomes. We share the responsibility of reinforcing these benefits with patients so they are more likely to obtain valuable screening tests.

Colorectal cancer screening tests are recommended for everyone between the ages of 45 and 75 years old. Colonoscopies are generally recommended once every 10 years, and there are now a variety of stool-based tests in addition to visual (structural) exams that can be used for screening purposes. Starting the recommended screenings at 45 years old can help catch polyps before they become cancerous or detect colorectal cancer in its early stages, when treatment is most effective. Treatment for colorectal cancer in its earliest stage can lead to a 90 percent survival rate after five years.

Breast Cancer Screening:

Breast cancer is the second most common cancer in women in the United States. Breast cancer contributes to about 42,000 deaths in women and 500 deaths in men each year. Your encouragement for regular screening mammograms and self-administered breast exams can help save lives.

Screening mammograms are recommended for women aged 40 and above, with varying frequencies based upon age, family history, symptoms, and other risk factors for breast cancer. Mammograms can help diagnose breast cancer at an early stage, when there is a wider range of treatment options and better chance of survival.

Our Care Managers discuss the advantages of colonoscopies and mammograms with members. We appreciate your also educating patients about their screening options during office visits. Let's continue to work together to reinfoce the importance of such preventive measures!

RISK ADJUSTMENT

Our goal is to provide our members with excellent health care services. We recognize that provider collaboration is necessary in delivering optimal care, and we appreciate that you ensure all member conditions are evaluated, treated, and monitored appropriately. We are happy to work with you to coordinate annual wellness visits where member-specific plans of care can be developed and documented.

Medicare Advantage Plans like ours are required by the Centers for Medicaid and Medicare Services (CMS) to participate in the process of capturing all relevant conditions that might impact a patient's health care acuity. Hierarchical Condition Categories (HCCs) are used in CMS's Risk Adjustment program to assist in assessing the disease burden that might contribute to a particular member's health. When you submit a claim, the diagnosis codes included in the claim are ultimately transmitted to CMS, where they are then converted into HCCs.

Proper HCC assignment is often driven by the thoroughness of the annual wellness visit. In order for HCCs to be accurately assigned, CMS dictates that the patient must be seen by a medical provider, and chronic conditions must be recaptured in the patient's medical record, each calendar year. The annual wellness visit affords providers the opportunity to review overall health status, monitor chronic conditions, and investigate any acute issues. The annual wellness visit also provides the opportunity to develop an effective clinical plan of care for the coming year.

Commensurate with properly capturing accurate diagnosis codes, CMS requires that the medical record and clinical documentation clearly articulate:

- All of the beneficiary's identified chronic conditions;
- Any acute conditions existing at the time of the visit;
- Each diagnosis being addressed;
- Status of each identified condition; and
- Plan of treatment crafted for each specific diagnosis.

Simply listing a medical condition on an active problem list, or in the past medical history, does not always reflect the breadth of treatment and care the patient might be receiving for that condition. Therefore, the medical record should align with all current diagnoses that are documented, coded, and reported to the highest appropriate degree of specificity on your claim form.

Provider documentation is key to accurate HCC assignment and, ultimately, ensures that we can effectively partner with you to coordinate all of the necessary services needed by each of our members, your patients. We value our provider relationships and look forward to our continued collaboration in providing topnotch care.

Annual wellness visits, particularly those scheduled early in the calendar year, play a critical role in facilitating the delivery of high-quality care.

Are You An FDR?

FDR stands for **F**irst Tier, **D**ownstream, or **R**elated Entity

IF you are contracted to service CPHL members as a(n):	**THEN**, you are an FDR. FDRs share compliance responsibilities with us, and we appreciate your help! FDR compliance requirements include, but are not limited to:
• Individual provider • Group practice • Hospital • Independent Physician Association (IPA) • Ancillary provider (e.g., laboratory, radiology, or dialysis facility) • Dentist • Behavioral health provider • Benefit manager • Anyone else who provides administrative or health care services on behalf of CPHL	• Having a Code of Conduct • Providing Fraud, Waste, and Abuse (FWA) training to applicable staff • Screening your organization for exclusions and conflicts of interest • Reporting noncompliance and potential FWA • Retaining records of compliance efforts for ten years • Conducting oversight of internal operations and subcontractors

Please contact us at (844) 292-4211
with any questions or concerns about your role as an FDR.

Calling All Social Day Care Facilities!

Are you Home and Commuity-Based Services (HCBS) compliant? According to the New York State (NYS) Department of Health (DOH), we are already well into Phase 2 of the key provisions of the HCBS Final Rule for Social Adult Day Care (SADC). **Full compliance with the HCBS Final Rule is expected by March 17, 2023!**

Below are some key requirements included in the Final Rule for Social Adult Day Care Facilities; you must:

- Be selected by the individual (and/or their authorized representative) among other SADC options.
- Be physically accessible to the individuals supported.
- Be integrated in, and support full access to, the greater community.
- Provide access to food and visitors at any time.*
- Ensure rights of privacy, dignity, respect, and freedom from coercion and restraint.
- Optimize an individual's autonomy and independence in making life choices.
- Facilitate an individual's informed choice about their services and who provides them.
- Provide freedom and support to control one's own schedule and activities.*

*Under certain conditions, this standard can be modified. Any modification must be supported by a specific assessed need and justified in an individual's person-centered service plan.

In addition to the settings standards above, the HCBS Final Rule also requires a person-centered planning process. To achieve this standard, you must obtain a social history, also known as the Individual Experience Assessment (IEA), as part of the initial service plan as well as annually thereafter, unless changes to the member's conditions warrant earlier. Having a person-centered plan that includes the desired outcomes of participants, a key standard within the Rule, means that person-centered plans will often include a focus on personal relationships and preferred activities, in addition to health and safety related outcomes.

Reference: https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policy/hcbs_sadc_facts.htm

I ♥ NY

Summer Highlights

Refer a Colleague!
Diabetes Medication Update
HEDIS Now
Preventative Screenings
Risk Adjustment
Social Day Care Facilities
Are you an FDR?

Enjoy Our Revamped Provider Newsletter!!

CENTERS PLAN FOR HEALTHY LIVING

Presort Standard
U.S. Postage
PAID
Hicksville, NY
Permit No. 885

Summer 2022

CPHL Contact Guide

CENTERS PLAN FOR HEALTHY LIVING

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 (I-SNP)	1-877-940-9330
Dual Coverage Care (D-SNP)	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: 1-800-788-2949