ProCare ADVANTAGE

Provider Newsletter

Q2 2024

Plan Website - For Providers

The Plan Provider Website contains important information for Provider and Facility Staff. To access additional information on topics included in this newsletter, access the Plan website and click on "**For Providers**," the following folders display with links to the specific sections.

SHOP PLANS | FOR PROVIDERS | FOR MEMBERS | CONTACT US | FIND A PROVIDER/PHARMACY

- Provider Documents
- Join Our Network
- Claims
- Patient Referral Requests
- For Prescribers and Pharmacies
- Find A Drug
- Provider and Pharmacy Directory

Visit the plan website at: **ProCareAdvantagePlan.com**

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2024 System Changes

Align Senior Care has implemented new platforms for the 2024 plan year to continue elevating your experience as a provider working with our plan. Please ensure you are utilizing the information below to contact us as necessary.

System/Process	Information
Provider Portal	**https://secure.healthx.com/ProCareAdvantage.provider**
Electronic Claims EDI Clearinghouse	The **Medical** claim clearinghouse is changing to **Availity**. Submit claims to: **PTX01** Continue to submit Dental claims to **Liberty Dental** using Payer ID CX083
For Providers unable to submit Electronic Claims, 2024 dates of service paper claims can be submitted to	Medical Claims: **PO Box 815** **Glen Burnie, MD 21060-0815** Dental Claims: PO Box 401086 Las Vegas, NV 89140
Member ID Card	Members will receive new ID Cards
Plan Mailing Address	**10900 Nuckols Road, Suite 110** **Glen Allen, VA 23060**

It is our goal to assist you in providing the highest level of service and satisfaction to our members through your network participation. If you have any questions or need further information regarding the changes listed, please call 1-844-206-3719 (TTY 711) or email us at: **procarecustomerservice@allyalign.com**.

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!

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. Take the survey here: **https://forms.office.com/r/T69K9dhKuG**

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.

Yearly SNP MOC Training Requirement

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, visit the **Model of Care Training** section of the provider website: **https://procareadvantageplan.com/model-of-care-training-attestation/-attestation/**

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

Quality Highlights

As a healthcare provider, your role is pivotal in aiding our members living with chronic conditions by advocating for regular screenings. This promotes an enhanced quality of life and helps mitigate complications linked with diabetes and hypertension.

We track the quality of care for members with diabetes using nationally recognized measures from the Healthcare Effectiveness Data and Information Set (HEDIS®) created by the National Committee for Quality Assurance (NCQA) and adapted measures endorsed by the Pharmacy Quality Alliance (PQA).

Comprehensive Diabetes Care

Focused measures related to diabetes care that are tracked include:

- **Glycemic Status Assessment for Patients with Diabetes (GSD)**: The percentage of members ages 18 to 75 (18-65 ISNP members) with diabetes (type 1 and type 2) whose HbA1c level during the measurement year is <9%
- **Eye Exam for Patients with Diabetes (EED)**: The percentage of members ages 18 to 75 (18-65 ISNP members) with diabetes (type 1 and type 2) who have a retinal eye exam by an eye care professional to screen or monitor for diabetic retinal disease annually or have a negative retinal or dilated eye exam in the year prior
- **Kidney Health Evaluation for Patients with Diabetes (KED)**: The percentage of members ages 18 to 85 (18-65 ISNP members) with diabetes (type 1 and type 2) who received a kidney health evaluation during the measurement year. An evaluation includes:
    - A blood test for kidney function (estimated glomerular filtration rate, or eGFR) AND
    - A urine test for kidney damage (urine albumin-creatinine ratio, or uACR)
- **Medication Adherence for Diabetes Medications**: The percentage of members with a prescription for diabetes medication (not including insulin) and fill their prescription often enough to cover 80% of the time they are supposed to be taking the medication during the measurement year
- **Statin Use in Persons with Diabetes**: The percentage of members ages 40-75 who have filled prescriptions for diabetes medication and received a statin medication fill during the measurement year

Tips to Close Gaps in Care:

- Monitor the hemoglobin A1c regularly and capture the result through submission of the CPTII code to identify control*
- Schedule an annual retinal or dilated eye exam by an eye care specialist and submit the CPTII code*
- Order an eGFR AND a urine albumin-creatinine ration (uACR) test annually. Both tests are completed with an order for a Kidney Profile
- Monitor medication adherence and communicate with the member and other care team members (facility, PCP) if non-adherence is identified to determine root cause and steps to improve adherence
- Use the ®HEDIS Gap report and Medication Adherence Report to easily identify members gaps in care

** Refer to the QI Resource Guide located in the Provider Documents section of the Plan website for a list of codes to consider.*

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Hypertension Management

Hypertension is highly prevalent and frequently undertreated in older adults. Effective management of hypertension can slow disease progression, prevent complications and development of comorbidities, reduce care transitions, and improve the quality of life.

Focused measures related to hypertension management that are tracked include:

- **Controlling High Blood Pressure (CBP):** The percentage of members ages 18 to 85 (18-65 ISNP members) with a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg). The last blood pressure obtained during the calendar year is used to determine control
- **Medication Adherence for Hypertension (RAS Antagonists):** The percentage of members with a prescription for a blood pressure medication (angiotensin converting enzyme inhibitor, angiotensin receptor blocker, or direct renin inhibitor drug) who fill their prescription often enough to cover 80% of the time they are supposed to be taking the medication during the calendar year. Medication adherence is determined using pharmacy claims data

Tips to Close Gaps in Care:

- Monitor the member's blood pressure regularly and capture the result through submission of the CPTII code to identify control
- Consider repeat blood pressure measurement during the visit if the initial blood pressure is >140/90
- Schedule follow up visits monthly, at a minimum, when blood pressure is above goal
- Monitor medication adherence and communicate with the member and other care team members (facility, PCP) if non-adherence is identified to determine root cause and steps to improve adherence
- Use the ®HEDIS Gap report and Medication Adherence Report to easily identify members gaps in care

CPT II Codes to Close Gaps in Care:

CPT CAT II Code	Description
3074F	Systolic < 130 mmHg
3075F	Systolic 130-139 mmHg
3077F	Systolic ≥140 mmHg
3078F	Diastolic < 80 mmHg
3079F	Diastolic 80-89 mmHg
3080F	Diastolic ≥ 90 mmHg

Refer to the QI Resource Guide located in the Provider Documents section of the Plan website for more detail.

Make It Easy for Patients 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 the Provider Information Change form located here:
https://procareadvantageplan.com/wp-content/uploads/2024/07/Provider-Information-Change-Form.pdf

By providing this information promptly, you will ensure that patients can reach you for needed care.

Send the Provider Information Change Form to: contracting@procareadvantageplan.com

Fraud, Waste and Abuse

Our plan has policies and procedures to identify fraud, waste, and abuse in its network, as well as other processes to identify overpayments within its network and to properly recover such overpayments. These procedures allow the Plan to report potential fraud or misconduct related to the Medicare program to the appropriate government authority as specified at 42 U.S.C. § 1395w-104 and 42 C.F.R. § 423.504(b)(4)(vi)(H), and policies and procedures in place for cooperating with CMS and law enforcement entities.

The evaluation and detection of fraudulent and abusive practices by the plan encompasses all aspects of plan business. All employees, contractors, and other parties are required to report compliance concerns and suspected or actual misconduct without fear of retaliation for reports made in good faith. The Compliance Officer may be contacted anonymously in the following manner:

- Calling the toll-free Compliance Hotline at:
  1-844-317-9059, TTY 711
- By email at:
  compliance@procareadvantageplan.com
- By mail at:
  ProCare Advantage
  Attn: Compliance Department
  2537 Golden Bear Drive
  Carrollton, TX 75006

All such communications will be kept as confidential as possible, but there may be times when the reporting individual's identity may become known or need to be disclosed to meet requirements of any governmental review actions. Any employee, contractor, or another party that reports compliance concerns in good faith can do so without fear of retaliation.

Also, as part of an ongoing effort to improve the delivery and affordability of healthcare to our members, our plan conducts periodic analysis of all levels of Current Procedural Terminology (CPT), ICD-9/ICD-10 and HCPCS codes billed by our providers. The analysis allows us to comply with its regulatory requirements for the prevention of fraud, waste, and abuse (FWA), and to supply our providers with useful information to meet their own compliance needs in this area. We will review your coding and may review medical records of providers who continue to show significant variance from their peers.

Credentialing

Practitioner Credentialing

Our plan utilizes CAQH to credential all practitioners into the plan network. All practitioners are re-credentialed every 36 months as required by CMS. To avoid plan termination based on credentialing status, ensure to maintain your CAQH profile, attest on a quarterly basis and update your contact information. All credentialing communications are sent via email to the credentialing contact listed on your CAQH application. To protect your information, we are not able to respond or send credentialing details on the status of your application to any outside sources not listed on your credentialing application.

Don't have CAQH? If you do not have CAQH, you may sign up here: **CAQH ProView - Getting Started**. If you do not have CAQH and must submit a paper application, fill out the state mandated credentialing application for your state according to your specialty and submit the paper application with all supporting documentation to the plan.

Organizational Credentialing

Our plan utilizes a facility credentialing application for all organizations. It's crucial to include supporting documentation with the application upon submission. As part of the credentialing criteria, we won't accept or process any other application types or forms. To obtain a copy of the application, please reach out to: **contracting@procareadvantageplan.com**

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

Visit the plan website for latest provider manual: **ProCareAdvantagePlan.com**

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.

Contact Us!

1-844-206-3719 (TTY 711)
procarecustomerservice@allyalign.com

ProCare Advantage is an HMO I-SNP with a Medicare contract. Enrollment in ProCare Advantage depends on contract renewal. ProCare Advantage complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.