Provider Check Up

HPP Participating Providers Newsletter | **SUMMER 2022**

Required Training Reminders

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

If you are a provider who has at least one Health Partners Medicare Special (D-SNP) member assigned to your practice, at least one person on your staff who is involved in the care of our dual-eligible special needs plan (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: https://elearning.easygenerator.com/08cc87de-0188-4059-a681-70a6ae8eea2e/#/login

It will take approximately 10 minutes to complete the course. Complete by October 31, 2022.

Annual Orientation and Training

Register now for an upcoming quarterly provider orientation and training for new and existing providers.

In addition to the live webinar, there are two alternative methods for completing the required training:

1. Request a face-to-face training by emailing providerEducation@hpplans.com
2. Download https://www.healthpartnersplans.com/media/100736177/2022-aot.pdf to review with your staff. Simply review the information, complete the attestation and click "submit" to complete the requirement by December 31, 2022.

Medicaid Expansion is Coming

HPP's Medicaid program will be offered throughout the entire Commonwealth! As previously communicated, open enrollment of the HealthChoices program across the Commonwealth of Pennsylvania will occur from June 20 to August 17. All eligible members will begin to receive communications on June 20 from the Pennsylvania Department of Human Services (DHS) regarding this timeline. Members who are currently enrolled with a managed care organization (MCO) no longer offering their products in the member's county effective September 1, 2022 will be required to select a new MCO.

For your reference we have highlighted the MCOs who will no longer offer their products in each HealthChoices zone.

HPP will be offering our award-winning Medicaid program in all five zones and welcomes the opportunity to care for those members who will need to find a new partner for their health plan needs.

As a provider that is contracted with HPP, at the request of the patient, or as a matter of a course of treatment, you are permitted to answer any questions the patient may have related to the plans we offer, including cost sharing and benefit information. If the patient is interested in learning more about the plans HPP offers, please refer them to our Member Relations team **1-800-553-0784 (TTY 1-877-454-8477)** so that we may answer any questions they may have. In addition, our website, www.HPPlans.com, will provide them with valuable information about our benefits along with other information that could help in their decision making.

We appreciate your support and are here to assist in answering any questions you may have regarding this procurement process. Please feel free to contact our Provider Services Helpline at **1-888-991-9023** (Monday – Friday, 9 a.m. – 5:30 p.m.).

Monitoring High Blood Pressure During In-Office Visits

"White coat syndrome" is a phenomenon that occurs when a patient's blood pressure registers higher in a doctor's office than it does in other settings, such as at home. Whether from anxiety about the visit or the stress of trying to get to an appointment on time, systolic pressure can register 10-30 mmHg and the diastolic reading 5mmHg higher than what is typical for that patient. For those who are already prescribed medication for hypertension, it's good practice to retake a blood pressure that registers 140/90 or higher, waiting until a bit later in the visit to do so. Ideally, the patient should be sitting in a relaxed position, with their legs uncrossed, their arm supported, and the BP taken with an appropriately fitting cuff. While automatic blood pressure machines are a convenient way to record pressure, a manual measurement taken by a clinician or well-trained ancillary staff member might provide a more accurate standard of reference and should be considered, especially if you suspect that "white coat syndrome" may be a factor in a patient who is compliant with medication and diet.

Reference: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6233698/

Medicaid and the Public Health Emergency

As conversations around the Public Health Emergency (PHE) continue, we are highlighting an important resource for members who may no longer qualify for Medicaid at the end of the PHE.

Currently, DHS estimates that around 200,000 members will lose Medicaid coverage at the end of the PHE. Considering this, DHS is focused on ensuring enrollees maintain access to quality health care. Those who no longer qualify for Medicaid at the end of the PHE can find help through Pennie. Pennie is Pennsylvania's marketplace for health insurance plans and supplies coverage through the American Rescue Plan.

Pennie has yearly open enrollment from November 1 until January 15. Outside of that timeframe, people can enroll through Qualifying Life Events, such as losing Medicaid coverage. In addition, those who reported income that is at or below 150% of the Federal Poverty Guidelines are eligible for a special enrollment period.

You can help ensure continued coverage of care for your patients by informing them about Pennie. Patients can learn more about their choices by visiting https://pennie.com/ or by calling the Pennie contact center at **1-844-844-8040**.

Addressing the Opioid Crisis

Opioid crisis and our roles as providers

According to the CDC, there were more than 100,000 drug overdose deaths in the United States from April 2020-April 2021, and this number does not include those who died from other complications such as hepatitis from using dirty needles, or HIV infection. We all know this is a significant issue, and despite all the discussion and initiatives, it seems at times that America's struggle to conquer this demon are reminiscent of the struggle an addict has.

To help our prescriber partners, Health Partners Plans wants to share information regarding resources available to prescribers to empower them to help any patients who may have an addiction, or who want to ensure they are minimizing any potential for patient addiction, while still ensuring adequate pain management.

General resources

Many prescribers are up to date on the latest opioid prescribing guidelines, which is a good place to start to address the problem. Another helpful tool a prescriber can utilize is the CDC's Opioid Guideline Mobile App, which can offer a quick and efficient reference, and is available on Google Play and the Apple app stores.

Additionally, it is good practice to consider the necessity of opiates. Could the patient make do with NSAIDs? Is their reported pain more consistent with neuropathic pain, even if they aren't diabetic, in which case perhaps a gabapentin would be preferred? Can we apply non-pharmacological or lifestyle choice changes to improve patient pain? If possible, we should exhaust all options before moving on to opiates.

Opiate dosing

There are some things that are easy to keep in mind that a help reduce the risks, such as keeping opioid doses lower than >50 MME, or "Morphine Milliequivalents," which refers to the relative strength of the opiate you are prescribing compared to morphine. For example, 33mg of oxycodone/day is equivalent to 50 MME. Doses under this threshold are less likely to result in addiction.

Keep therapy as short as possible

Additionally, one of the factors that drives opiate addiction is the severity of the withdrawals. Longer durations of treatment with opiates can lead to desensitization and an upregulation of the μ-opioid receptors. This leads to withdrawal when the patient is unable to obtain opiates. There is also evidence to suggest that addiction can begin in as few as five days. Therefore, prescribing opiates for the shortest amount of time possible is crucial, as it reduces the likelihood of addiction and the unpleasant withdrawal symptoms, which result in many patients seeking relief, often through illicitly obtained opiates.

Potentials for interactions between opiates and other drugs

There is an ongoing issue with the concurrent prescribing of opiates with benzodiazepines. The known drug cocktail, sometimes called "The Trinity," involves taking an opiate with benzodiazepines and carisoprodol – many pharmacists and prescribers are educated to look out for these three drugs together. However, we must not neglect the dangers that simply prescribing an opiate with a benzodiazepine may pose. Both medications can lead to respiratory depression and ultimately death as a result. This risk is heightened by the tendency for patients not to consider that alcohol can interact with their medications.

Of course, patients who have anxiety disorders may still require treatment. If this is the case, then consider therapeutic alternatives and reserve benzodiazepines as a last resort.

Pennsylvania resources for prescribers

Because of the wide-reaching impacts of opiate addiction, the state of Pennsylvania has a dedicated portal with information and resources the state makes available to help prescribers in treating patients with addiction issues. The portal notably features a portion on how to handle addiction issues surrounding Covid-19.

For patients who are on long-term opioid therapy, consider adding an opioid antagonist, such as Narcan, and instructing patients and their relatives on how to properly use it. If the patient has no interest at that time, still inform them that Pennsylvania has a standing order for Narcan, meaning that should they later believe it prudent to obtain some for a potential overdose, they can do so without a prescription.

We at Health Partners Plans recognize that the opioid crisis is a complex societal issue, and we offer our own resources to aid prescribers. We hope that together, we can help to curb this terrible crisis and help our patients to live their lives free of the terrors of addiction.

Coding Well Child Visits

One of Health Partners Plans' primary goals is to ensure our youngest members receive the preventive care they need. That's why we stress that **you can often complete a well child visit when a child comes in for a sick visit**. This opportunity exists when a provider has determined that the condition, illness or injury that led to the sick visit does not impede the ability to complete a well child visit and that the child is eligible for the well visit, per their care gap report.

Based on our claims data, many provider offices miss this opportunity, and well child visits often do not occur or the submitted claims do not accurately capture the rendered services. When services are documented and billed properly, offices can significantly increase revenue. We want to ensure that our providers are reimbursed properly for the care provided. Approximately 25 million Americans have asthma, which leads to over 9 million doctor offices visits and 1.5 million emergency department visits per year. As you may know, the NIH published the new Asthma SMART Guidelines in December of 2020. The key topic updates include:

Submitting proper claims

Your office can submit claims for *both* a sick visit and a preventive well child visit for services provided on the same day, provided that **Modifier 25** is added to the claim.

When a child presents for a sick visit, consider performing the services of the preventive well child visit, if appropriate, in addition to rendering care for the presenting problem. The components of a well child visit, as indicated by the Early Periodic Screening, Diagnosis and Treatment (EPSDT) and Bright Futures criteria, are as follows:

- Health and developmental history
- Physical exam
- Laboratory tests (as appropriate for the age of the child)
- Immunizations (use all visits, preventive and sick, if medically appropriate)
- Health education and age-appropriate anticipatory guidance (including schedule of care and dental home referral)

Please note the following coding reminders/clarifications:

- Modifier 25 *must* be billed in **the first modifier position with the applicable E&M code** for the allowed sick visit. When Modifier 25 is *not* billed in the first position, the sick visit will be denied.
- Providers can bill the age-appropriate preventive CPT codes (**99381-99385**, **99391**, **99392-99395**), and **99461**) and a separate identifiable **E&M** code with Modifier 25.
- Well child visits should be reported with the following diagnosis codes: **Z00.00**, **Z00.01**, **Z00.5**, **Z00.8**, **Z00.110**, **Z00.111**, **Z00.121**, **Z00.129**, **Z02.0-Z02.6**, **Z02.71**, **Z02.82**, **Z76.1**, and **Z76.2**.
- Appropriate diagnosis codes must be billed for the respective well child visit and sick visit.

Examples of Proper Coding

Example	E&M Description	Well Child Visit Diagnosis Code (in the Primary Position)	Well Child Visit E/M Code	Allowable Sick Visits with Modifier 25 (when billing with a Well Child Visit)
#1	New Patient E&M visit	Z00.121	99382	99202-25
#2	Established Patient E&M visit	Z00.121	99392	99212-25
#3	Established Patient E&M visit	Z00.129	99394	99213-25

Note: Providers must have proper medical record documentation to support the CPT codes and the E/M codes billed. This documentation should be able to be separated into two distinct notes that will support both E/M services billed for the visit.

Adolescent well child visits (ages 12-20 years)

For our adolescent members,HPP is currently offering an incentive for ages 12-21 years old (Medicaid), 12-18 years old (CHIP). If your patient comes in and they complete at least one comprehensive wellcare checkup, they will be eligible to earn reward points. Reward points can be redeemed for items such as gift cards.

If you have questions or concerns, call the Provider Services Helpline at **1-888-991-9023**.

Asthma Medication Ratio

Quality Care Plus (QCP) is HPP's primary care physician incentive program for our Medicare, Medicaid and CHIP health plans. It is a transparent tool that is designed to recognize and reward practice's performance in delivering quality services throughout the year. Asthma Medication Ratio (AMR) is a key 2022 measure. Specific details of each measure are provided in the 2022 QCP manual – including measure descriptions, requirements, tips for improvement, benchmarks and PMPMs. AMR applies to Medicaid and CHIP members.

Recent data suggests that roughly 1 in 13 Americans have asthma, approximately 25 million people. In addition, more than 1 million emergency department visits each year are for asthma-related concerns. While there is no cure for asthma, providers can help patients manage their asthma to prevent severe exacerbations and disease progression. Managing this condition could help save the U.S. billions of dollars in medical spending. The prevalence and cost of asthma have increased over the past decade, demonstrating the need for better access to care and medication.

Asthma Medication Ratio HEDIS Measure

The percentage of members ages 5-64 years who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.5 or greater during the measurement year.

Asthma Medication Ratio = Units of Controller Medications/Units of Total Asthma Medications

- 1 medication unit is equal to: oral medication lasting 30 days or less, one inhaler, or one injection
- Units of controller medications = the total amount of controller medications dispensed during measurement year

Asthma Controller Medications

  - Anti-asthmatic combinations: dyphylline-guaifenesin (oral)
  - Antibody inhibitors: Omalizumab (injection)
  - Anti-interleuikin-4: Dupilumab (injection)
  - Anti-interleuikin-5: Reslizumab, Benralizumab, Mepolizumab (injections)
  - Inhaled steroid combinations: budesonide-formoterol, fluticasone-salmeterol, fluticasone-vilanterol, formoterol-mometasone (inhalations)
  - Inhaled corticosteroids: beclomethasone, budesonide, ciclesonide, flunisolide, fluticasone, mometasone (inhalations)
  - Leukotriene modifiers: montelukast, zafirlukast, zileuton (oral)
  - Methylxanthines: theophylline (oral)

- Units of total asthma medication = the total amount of controller AND reliever medications dispensed during measurement year

Asthma Reliever Medications

  - Short-acting, inhaled beta-2 agonists: albuterol, levalbuterol (inhalations)

For more information about Asthma Medication Ratio, please review the 2022 QCP Manual.

TIPS TO IMPROVE QCP PERFORMANCE

- Discuss medication adherence during all visits and incorporate as part of pre-visit checklist.
- Educate your patients and their family members about self-managing, identifying triggers and the importance of adhering to the medicine.
- Schedule regular follow-up visits for your patients with persistent asthma.
- Document patients' medication lists and the date medications were prescribed.
- Leverage pharmacies that provide in-home delivery services.
- Review HPP's weekly member level reports in our provider portal to identify noncompliant members.

Pharmacy Lab

The Integrated Care Plan (ICP) program is a pay for performance program implemented by the Department of Human Services (DHS) for Medicaid recipients. In the fall of 2015, the initiative was put into place to encourage stronger collaboration between physical health and behavioral health managed care organizations, as well as providers.

The initiative focuses on members ages 18-64 who are diagnosed with serious and persistent mental illness – commonly referred to as SPMI. The diagnoses that the state includes into this category are:

- 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

It is well established that adults with SPMI have a higher mortality rate than the overall general population. The prevalent cardiovascular risk factors in in this population are diabetes, obesity, dyslipidemia and hypertension. These risk factors are driven by decreased physical activity, poor diet, higher rates of smoking and side effects of commonly prescribed antipsychotic medications.

Diabetes is also very common in patients with SPMI. Antipsychotic medications used for the treatment of these conditions are associated with weight gain, impaired glucose metabolism, exacerbation of existing diabetes and dyslipidemia.

For these reasons, a portion of the ICP program is focused on stressing the importance of screening and monitoring existing cardiovascular disease and diabetes in adults with severe and persistent mental illness. The following measures are part of the ICP program and are modified HEDIS measures:

- Diabetes Screening for People with Serious and Persistent Mental Illness who are using Antipsychotic Medications (SSD): Adults 18–64 years of age with serious and persistent mental illness, who were dispensed an antipsychotic medication and require a diabetes screening test
- Cardiovascular Monitoring for People with Cardiovascular Disease and with Serious and Persistent Mental Illness (SMC): Adults 18–64 years of age with serious and persistent mental illness and cardiovascular disease, and require an LDL test

If an HPP member has serious mental illness and requires one of the above screenings, a list is available via the Care Gap Report on NaviNet.

In addition, the following HEDIS measure is an additional measure focused on lab monitoring in the setting of serious mental illness:

- Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD): Adults 18-64 who are diagnosed with schizophrenia and diabetes require **both an LDL-C test and an HbA1c test**.

Please follow up with these patients to discuss the importance of adequate screening and continuous monitoring for their mental and physical wellbeing.

HPP can help members with serious mental illness and comorbidities and/or significant barriers to treatment.

To refer members who need assistance to our Clinical Programs teams, call **215-845-4797** (8:00 a.m. to 4:30 p.m., Monday–Friday). If you have any additional questions, please call the Provider Services Helpline for any additional questions.

We appreciate your continued support in managing the needs of our members.

What is PrEP?

PrEP (pre-exposure prophylaxis) is medication taken by people at risk for HIV via sex or injection drug use that is highly effective when taken as prescribed. Studies have shown that with strict patient adherence, prescribed PrEP regimens can be up to 99% effective in preventing HIV from sex. Ongoing efforts to provide patient education about various PrEP regimens that fit patient-specific needs will help reduce HIV transmission and exposure.

There are currently 3 FDA approved PrEP regimens:

- Truvada – oral tablet
- Descovy – oral tablet
- Apretude – intramuscular injection

PrEP Medication	Indication	Dosing
Truvada (emtricitabine 200 MG / tenofovir disoproxil fumarate 300 MG)	At-risk adults and adolescents weighing at least 35 KG for PrEP to reduce the risk of sexually acquired HIV-1 infection	1 tablet by mouth daily CrCl ≥ 60 mL/minute: No dosage adjustment necessary CrCl < 60 mL/minute: Use is not recommended
Descovy (emtricitabine 200 MG / tenofovir alafenamide 25 MG)	At-risk adults and adolescents weighing at least 35 KG for PrEP to reduce the risk of HIV-1 infection from sexual acquisition, excluding individuals at risk from receptive vaginal sex	1 tablet by mouth daily CrCl ≥ 30 mL/minute: No dosage adjustment necessary CrCl < 30 mL/minute: Use is not recommended
Apretude cabotegravir 600 MG (3mL) extended-release injectable suspension	At-risk adults and adolescents weighing at least 35 KG for PrEP to reduce the risk of sexually acquired HIV-1 infection	May initiate with oral cabotegravir lead-in therapy prior to intramuscular injections or may precede directly to intramuscular injections without oral lead-in. Oral lead-in therapy: **Oral**: 30 MG once daily for 28 days. Administer Intramuscular initiation injection on the last day of oral lead-in, or within 3 days after. Initiation injections: **Intramuscular**: 600 MG once monthly for 2 doses; if using oral lead-in, first intramuscular initiation injection should be administered on the last day of oral lead-in, or within 3 days after. • Second initiation injection may be administered up to 7 days before or after the date the patient is scheduled to receive the injection. Continuation injections: **Intramuscular**: 600 mg once every 2 months, starting 2 months after the last initiation injection. • Continuation injections may be administered up to 7 days before or after the date the individual is scheduled to receive the injection. CrCl ≥ 15 mL/minute: No dosage adjustment necessary

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Why switch to an injection?

- Problems taking daily oral tablets as prescribed
- Patients who prefer receiving injections on a less frequent basis compared to taking daily tablets
- Patients who have serious kidney issues that prevent them from taking oral medications

The following is the formulary status of the HIV PrEP medications:

	Preferred
Medicaid and KidzPartners	• Emtricitabine 200 MG / tenofovir disoproxil fumarate 300 MG Tablet (generic Truvada) • Descovy 200-25 MG Tablet • Apretude 600 MG/3 ML Suspension

	Formulary	Non-formulary
Medicare (Prime and Complete)	• Emtricitabine 200 MG / tenofovir disoproxil fumarate 300 MG Tablet (generic Truvada) • Descovy 200-25 MG Tablet	• Apretude 600 MG/3 ML Suspension
Medicare (Special)	• Emtricitabine 200 MG / tenofovir disoproxil fumarate 300 MG Tablet (generic Truvada) • Descovy 200-25 MG Tablet	• Apretude 600 MG/3 ML Suspension

90-Day Supply Mail Order Pharmacy

Almost 1 out of 5 new prescriptions in the U.S. are never filled and 50% of people do not take them as prescribed. Unfortunately, this means that many members are not receiving the treatment they need for their health conditions. One of the causes for this is simply the difficulty some may have in obtaining their medications due to a busy schedule or transportation difficulties.

What may seem like a routine trip to a pharmacy may be challenging for some. However, Health Partners may be able to assist through our 90-day supply, mail order pharmacy and pharmacies that offer delivery options. For members whose treatment regimen has been stable, consider writing 90-day supplies for eligible medications. This decreases the frequency that members need to pick up their medications, so members do not have to travel to the pharmacy as frequently.

Members can obtain their prescriptions through mail order pharmacy. This way, medications will be delivered directly to the member. Health Partners Plans relies on a single mail order pharmacy to better serve our members, which is provided by CVS Caremark Mail Service Pharmacy. Prescriptions simply need to be sent to the CVS Caremark Mail Service Pharmacy which can be found at caremark.com/mailservice. Please note that some medications may not be available through mail order pharmacy.

In addition, a number of participating pharmacies offer delivery for our members. Please see the Health Partners Plans Provider webpage under the Tools and Resources or Provider Directory tabs to view the list. Please note this is not a comprehensive list of pharmacies and this list will be updated at least annually.

LARC Coverage

We at Health Partners Plans have some good news, which we hope will simplify things for prescribers and members alike.

HPP covers a variety of more traditional oral contraceptives for our Medicaid members. However, we know that some members have busy lives or are otherwise in situations which may complicate medication adherence. As prescribers, you may realize that members who desire contraception, but who deal with these challenges, may benefit from Long-Acting Reversible Contraception, or LARCs. These include devices such as intrauterine devices (IUDs) and implanted hormonal birth control. While they need to be administered by a healthcare provider, they work for years.

Contraceptives, including LARCs, are covered on the Health Partners Plans Medicaid Preferred Drug List (PDL) under the Pharmacy Benefit and are available from the pharmacy with a provider's prescription. For LARCs, the pharmacy can help coordinate delivery services to your office.

See below for a list of the preferred LARCs on Health Partners Plans Medicaid Preferred Drug List:

- Paragard Intrauterine Copper IUD
- Mirena IUD
- Skyla IUD
- Liletta IUD
- Kyleena IUD
- Nexplanon Implant

Working Wellness Zones

HPP wants to remind all provider groups that it is just as important for our healthcare workers to make their mental and physical health a priority as it is to provide high quality care to our members!

Working wellness: Our commitment at HPP is to recognize our providers' and support staff members' well-being inside and outside of work. It will look different to everyone based on where you are in life and your priorities. Wellness can be filtered through a myriad of lenses such as physical, mental or social.

Feeling well at work looks different to each of us. It can look like:

- Taking a lunch during your day
- Having the opportunity to exercise
- Thank you notes or tokens of appreciation
- Feeling supported
- Access to health care and benefits such as paid time off
- Empathetic and understanding leaders

We invite you to share this zone tool with your staff and encourage them to do self check-ins regularly.

What Zone are You in?			
Blue	**Green**	**Yellow**	**Red**
Sick	Happy	Frustrated	Mad/Angry
Sad	Calm	Worried	Mean
Tired	Feeling Okay	Silly/Wiggly	Yelling/Hitting
Bored	Focused	Excited	Disgusted
Moving Slowly	Ready to Learn	Loss of Some Control	Out of Control

Persistence of Beta-Blocker After a Heart Attack

Beta-blocker therapy is recommended after an acute myocardial infarction as long-term treatment to decrease the risk of having a secondary myocardial infarction. Beta-blockers, when started early, will reduce infarct size and mortality rate. It lowers the risk of death when continued long-term.

Although patients who have had a previous MI may need extensive care and lifestyle changes, providers can make a change in patients' overall quality of life when prescribing beta-blockers to increase heart health. Beta-blockers will work by decreasing the demand of the heart by reducing heart rate, blood pressure and contractility.

Persistence of Beta-Blocker Treatment After a Heart Attack HEDIS Measure

The percentage of members 18 years and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of acute myocardial infarction and who received persistent beta-blocker treatment for six months after discharge.

Some Beta-Blocker Medication Examples:

- Noncardioselective beta-blockers:
  - Carvedilol
    - Labetalol
  - Propranolol
- Cardioselective beta-blockers:
  - Atenolol
    - Bisoprolol
  - Metoprolol

Statin Therapy for Patients with Diabetes

From 1990 to 2019, type 2 diabetes has risen to the 6th leading health condition when it comes to the amount of years lost for patients in the United States. This shows the importance of not only treating this condition, but the complications that can come along with it. Increased glucose levels in blood vessels can lead to damage of blood vessel walls and nerves that allow the heart to function properly.

To prevent further complications of diabetes, statin therapy should be considered to minimize the risk of ASCVD and other cardiovascular complications. Healthcare providers can help decrease this risk by determining if patients with diabetes should be treated with statin therapy based on patient specific factors.

Statin Therapy for Patients with Diabetes HEDIS Measure

The percentage of those 40-75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who meet the following criteria.

Two rates are reported:

1. Received Statin Therapy: Patients who were dispensed at least one statin medication of any intensity during the measurement year.
2. Statin Adherence 80%: Patients who remained on a statin medication of any intensity for at least 80% of the treatment period.

Low Intensity	Moderate Intensity	High Intensity
–	Atorvastatin 10-20 MG	Atorvastatin 40-80 MG
–	Rosuvastatin 5-10 MG	Rosuvastatin 20-40 MG
Simvastatin 5-10 MG	Simvastatin 20-40 MG	Simvastatin 80 MG
Pravastatin 10-20 MG	Pravastatin 40-80 MG	–
Lovastatin 10-20 MG	Lovastatin 40 MG	–

The above are examples of some statin medications based on intensity.

Statin Therapy for Patients with Cardiovascular Disease

Cardiovascular disease (CVD) is an immense health and economic burden. Between 2017 and 2018, direct and indirect costs of total CVD were $378 billion. This shows the severity of cardiovascular related conditions that require adequate treatment options to prevent further complications. Statin therapy has been shown to decrease the buildup of plaque in the blood vessels, which reduces the risk of life-threatening complications. Providers can help patients by ensuring all patients with cardiovascular disease are treated with statin therapy.

Statin Therapy for Patients with Cardiovascular Disease HEDIS Measure

The percentage of males 21-75 years of age and females 40-75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria.

Two rates are reported:

1. Received Statin Therapy: Patients who were dispensed at least one high-intensity or moderate-intensity statin during the measurement year.
2. Statin Adherence 80%: Patients who remained on a high-intensity or moderate-intensity statin for at least 80% of the treatment period.

Moderate Intensity	High Intensity
Atorvastatin 10-20 MG	Atorvastatin 40-80 MG
Rosuvastatin 5-10 MG	Rosuvastatin 20-40 MG
Simvastatin 20-40 MG	Simvastatin 80 MG
Pravastatin 40-80 MG	–
Lovastatin 40 MG	–

The above are examples of some statin medications based on intensity.

Spotlight on Member Satisfaction and Customer Service

HPP's Investment in Member Satisfaction

HPP's post-visit survey was introduced in March 2018. After a pause in 2020 to evaluate the program, the post-visit survey resumed in April 2021.

The results of the 10-question survey impact a satisfaction measure in the QCP program. Top performers are rewarded with an additional PMPM payment, while low performers receive a reduced QCP payout.

HPP is committed to member satisfaction. We have invested time and resources to support provider groups in your efforts to make the member experience the best it can be.

Why is member satisfaction important? HPP and provider success count on it!

Survey Eligibility

HPP members who have completed a visit with their attributed PCP at a QCP site with more than 250 total HPP members (at the site level) are eligible to participate in the post-visit survey. A minimum of 30 completed surveys are required per site to be included in the satisfaction measure.

Members are only included in the sample on a bi-annual basis (January through June and July through December). Surveys are conducted a maximum of two times per year for members with multiple visits to avoid bias and survey fatigue. (This is only applicable if the survey is completed.)

Benchmarks are influenced by industry standards but are designed based on our network's historical performance, which improved greatly since restarting the surveys in April 2021. These benchmarks are reevaluated annually to align with network changes in performance.

For more resources, webinars and tip sheets, please visit the Improving Member Experience & Satisfaction section of the HPP provider website.

Continued on next page

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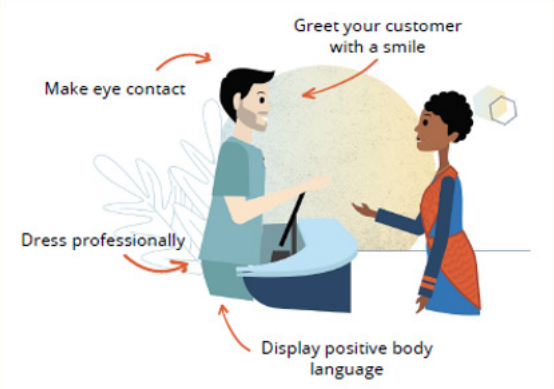
Check out these snapshots from PCDC tip sheets on how to build rapport with HPP members!

BUILD RAPPORT

Rapport is another term for building a genuine connection and a sense of friendliness with another person. Rapport can be established quite quickly, right from the beginning of your interaction.



CHOOSE YOUR WORDS WISELY

RESPONSE
thought-out, calm, measured

VS.

REACTION
quick, abrupt, unprepared

"I understand. Let me find out how I can resolve this for you."

"Are you sure that's what happened?"

EMPATHY
being able to put oneself another's shoes

VS.

SYMPATHY
agreeing with another's feelings

"I'm sorry you don't feel heard by your doctor. I can provide your anonymous feedback."

"I'm not suprised he said that! I don't like the doctor much either."

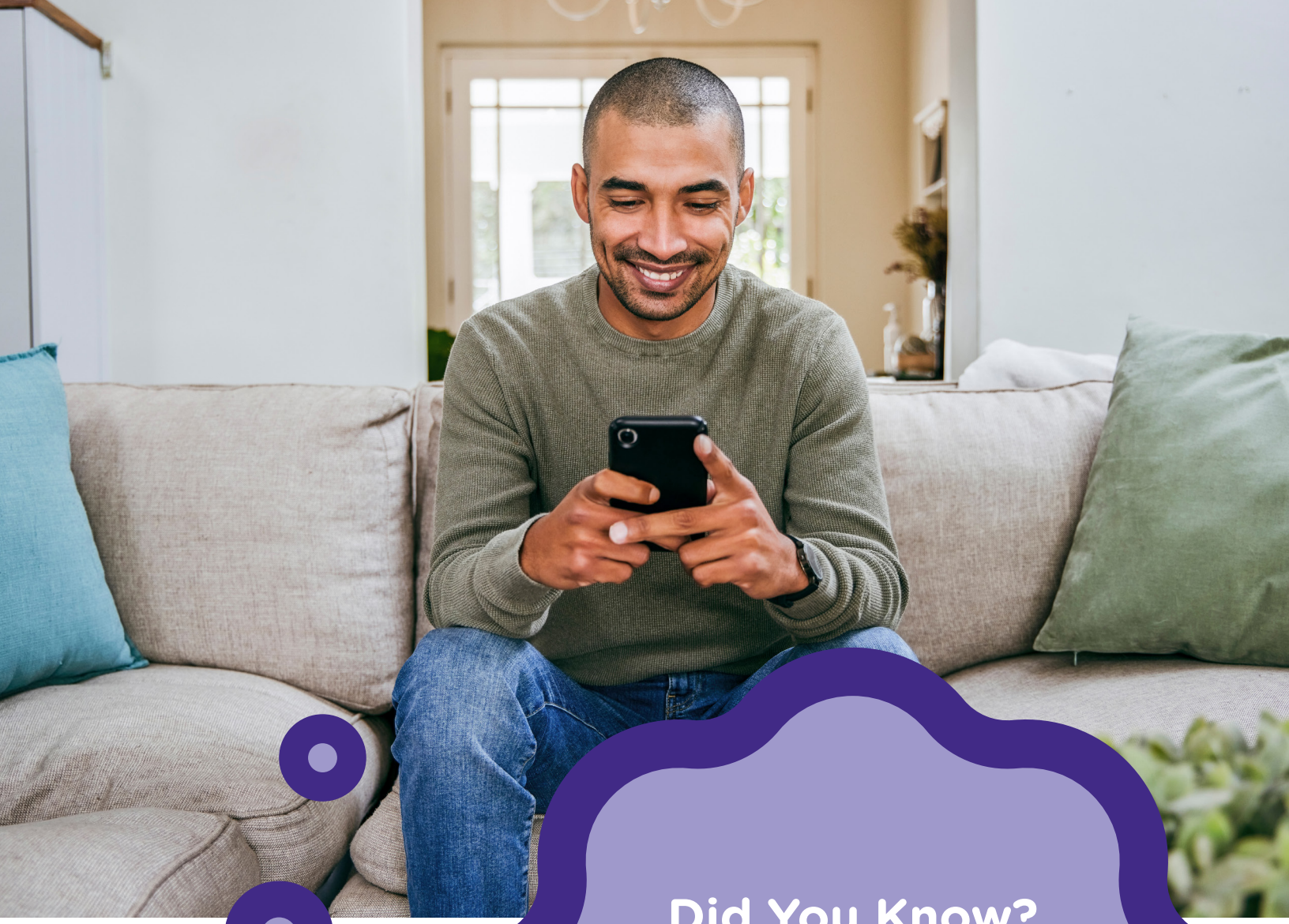
EMPOWER CUSTOMERS TO OVERCOME OBSTACLES

Give yourself positive self-talk. "Yes, this is tough, but I'm going to stay calm and solve the problem."

Take a deep breath. This isn't personal. Ask, "Can you tell me what happened?"

Listen actively. Let your patient talk. If there is off-the-topic rambling, gently redirect the patient back.

Assume good intent. You don't know what happened before your patient appeared at the counter. Perhaps they had a really difficult morning.



Did You Know?

HPP works with vendors who call members on our behalf to assist with care gap closure and outreach support! For more information, please reach out to your Network Account Manager (NAM).

Health Partners Plans HPP

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