ALIGN SENIOR CARE
A Curana Health Company

Provider Newsletter

Q2 2025

Plan Website – For Providers

The Plan Provider Website is a valuable resource for both Provider and Facility staff. For more details on the topics covered in this newsletter, please visit the Plan website and navigate to the "For Providers" section. There, you will also find the comprehensive **Online Provider Manual**.

We encourage all providers to regularly consult the Provider Manual, which includes essential information such as:

- Key Contacts
- Eligibility
- Member Benefits
- Billing and Claims
- Credentialing Requirements
- Quality Improvement
- Provider Participation Standards
- Member Rights and Responsibilities
- Plan Compliance Program

As a participating provider, it is vital to stay informed about the Plan's participation standards. Detailed descriptions of each standard can be found in the Provider Manual.

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

TABLE OF CONTENTS

Plan Website - For Providers 1
Credentialing Process......... 2
Quality Corner 2
Telehealth Update 5
Make It Easy to Find You 5
Provider Participation Standards....................... 6-11
Transplant Network.......... 11
Customer Satisfaction Survey 11

Contact Us

Provider Portal: **https://secure.healthx.com/AlignSeniorCare.provider**
Contact Us Page: **https://alignseniorcare.com/contact-us/**
Customer Service Phone: **1-855-855-0336 (TTY 711)**
Customer Service Email: **customerservice@alignseniorcare.com**

Credentialing Process Update: Transition to CredentialStream

We're excited to announce an upcoming change to how we manage provider credentialing.

Effective **September 1, 2025**, we will no longer be using Andros as our Credentialing Verification Organization (CVO). Instead, **we will oversee the credentialing process internally using a new, streamlined platform—CredentialStream.**

At this time, there is **no immediate impact to providers**, and no action is required. As we transition to CredentialStream, you may begin to notice credentialing-related communications—such as requests, notification letters, and reminders—being sent from our new email address: **CuranaHealth@verity.cloud**. If you do receive emails from our new email address, please log into the system directly with the provided log in credentials to upload missing documents and/or information.

If you have any questions about your current credentialing status, the change of platform, or plan credentialing requirements, email: **credentialingoperations@curanahealth.com**

What's New With CredentialStream?

The platform offers several exciting features designed to enhance your experience, including:

- A more user-friendly and intuitive interface
- Faster credentialing turnaround times
- Real-time application tracking
- Automated reminders and document submission tools
- Greater transparency throughout the process

We'll continue to share updates as we approach the go-live date. Thank you for your continued partnership and commitment to quality care.

Quality Corner

Our Plan is committed to delivering high-quality services, benefits, and health care to our members. To support this commitment, we conduct an annual member survey to gather feedback on the member experience. This includes areas such as provider communication, appointment access, and support services.

Beginning in January 2025, an independent survey vendor, SPH Analytics (SPH), administers the survey to a random sample of members or their designated representatives.

The insights gained from this survey are critical in helping us identify opportunities to enhance the services and care we provide. If a member asks about the survey, please encourage their participation and let them know it is a valuable opportunity for their voice to be heard.

For questions regarding the member survey, please email **QualityTeam@curanahealth.com**

Deprescribing In Older Adults: A Key to Safer, Healthier Aging

Deprescribing is the planned and supervised process of reducing or stopping medications that may no longer be beneficial—or may even be harmful—with the goal of managing polypharmacy and improving patient outcomes.

Unlike traditional, reactive approaches that address medication issues only after problems arise, deprescribing emphasizes a proactive, systematic review of a patient's entire medication regimen.

The goal is to identify and taper or discontinue medications that present more risks than benefits, including high-risk drugs or those contributing to adverse effects. This strategy helps address potential medication-related problems before they impact patient health and supports safer, more effective care.

Source: Michael Steinman, MD; Emily Reeve, BPharm(Hons), PhD. Literature review current through August 2024. Last updated October 30, 2023.

Older aults are particularly vulnerable to the risks of polypharmacy and adverse drug reactions. To promote healthier aging and improve clinical outcomes, routine medication reviews—and open discussions about potentially inappropriate medications—should be a standard part of care.

Deprescribing can significantly enhance quality of life for older patients by:

- Reducing the risk of falls
- Preserving or improving cognitive function
- Lowering the likelihood of hospitalizations and mortality

While deprescribing should be considered for all patients, special attention should be given to high-risk situations such as:

- Concurrent use of opioids and benzodiazepines
- Use of multiple anticholinergic medications in adults over age 65

Proactively identifying and addressing these opportunities supports safer prescribing and better outcomes for our aging population.

Here are some helpful resources for deprescribing:

- Evidence-based deprescribing guidelines and algorithms: **www.deprescribing.org/resources**
- 2023 American Geriatrics Society pocket guide to the BEERS Criteria: **https://gwep.usc.edu/wp-content/uploads/2023/11/AGS-2023-BEERS-Pocket-PRINTABLE.pdf**

Quality Corner continued

Clinical Practice Guidelines and Medical Necessity

Clinical Practice Guidelines and Preventive Health Guidelines

The Clinical Practice Guidelines and Preventive Health Guidelines are nationally recognized sources put in place to support the adoption and oversight of clinical practices and preventive health guidelines. We systematically review and adopt evidence-based Clinical Practice and Preventive Health Guidelines disseminated from peer-reviewed sources and organizations as recent technology or scientific findings change.

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

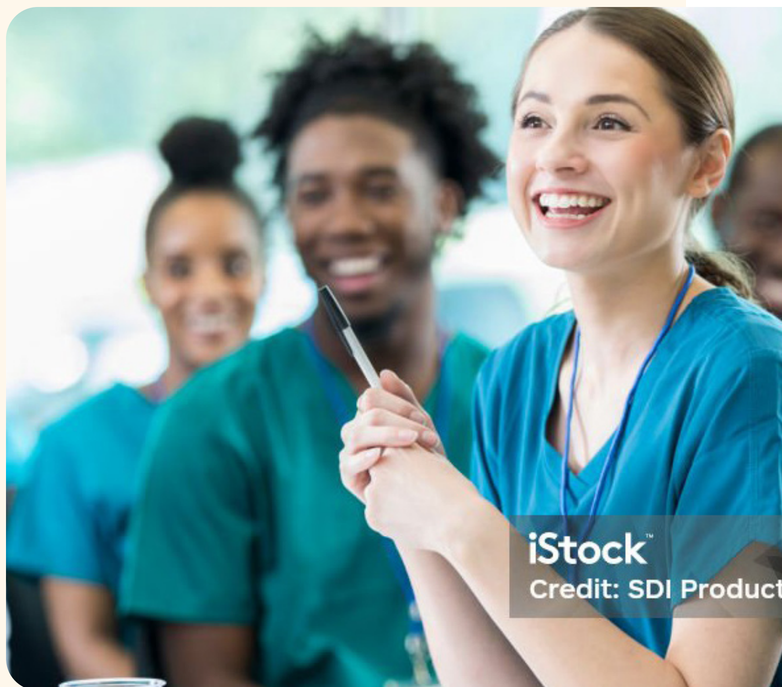
The guidelines will assist you in your practice to provide evidence-based care. Visit the Quality section of the Plan's website to view the full listing of guidelines.

Model of Care Training

The Model of Care (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 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



The Model of Care goals are:

- Improve access to medical, mental health, and social services
- Improve access to affordable care
- Improve coordination of care through an identified point of contact
- Improve transitions of care across health care settings and providers
- Improve access to preventive health services
- Assure appropriate utilization of services; and
- Improve member health outcomes

Yearly MOC training:

CMS requires initial and annual MOC training for all network and out-of-network providers who provide care to Special Need Plan members on a routine basis. If you currently service the Plan's special needs members, you must complete the SNP MOC training annually. To review the training, visit the Model of Care Training section of the provider website at: **https://alignseniorcare.com/model-of-care-training-attestation/**

2025 Telehealth Updates

CMS continues to expand and make changes to the allowed telehealth services and physician fee schedules. Through recent legislation, CMS has authorized the extension of the Medicare telehealth flexibilities from the COVID-19 public health emergency through September 30, 2025. To ensure your office is following telehealth service requirements and is referencing the most up to date guidance, visit the following resources:

- HHS.gov Telehealth Policy: **Telehealth policy | Telehealth.HHS.gov**
- Calendar Year 2025 Medicare Physician Fee Schedule: **Federal Register :: Medicare and Medicaid Programs; CY 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments**
- Telehealth and Remote Patient Monitoring: **mln901705_telehealth_services.pdf**

Make It Easy for Members to Find You

Accurate and complete provider information in our Provider Directory is essential to helping members find and access the care they need. The directory serves as a key resource for members seeking providers within our network. We encourage you to regularly review your directory listing and inform us of any updates or changes as soon as possible—and no later than thirty (30) calendar days before the effective date of the change.

To report updates, please contact your Plan Network Support Representative or call Provider Services. Timely updates help ensure that members can find and reach you when they need care most.

Provider Participation Standards

Please ensure that your office is in compliance with the following Plan Provider Participation Standards. These standards are essential to maintaining high-quality care and service for our members.

For additional information or clarification, please consult the Online Provider Manual or contact your Plan representative.

Dual Eligibles and Cost Sharing

For all members eligible for both Medicare and Medicaid, members will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for members enrolled in Medicare and Medicaid. Provider may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under Title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept the MA plan payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

Member Hold Harmless

Participating Providers are prohibited from balance billing Plan members including, but not limited to, situations involving non-payment by the Plan, insolvency of the Plan, or the Plan's breach of its Agreement. Provider shall not bill, charge, collect a deposit from, seek compensation or reimbursement from, or have any recourse against customers or persons, other than the Plan, acting on behalf of customers for covered services provided pursuant to the Participating Provider's Agreement. The provider is not, however, prohibited from collecting copayments, coinsurances, or deductibles for covered services in accordance with the terms of the applicable customer's Benefit Plan, or from collecting payment when rendering non-covered services if the provider complies with the requirements of the non-covered services section of the Provider Manual. Participating providers should call Provider Services to check on member cost-share responsibility if not listed on the member ID card.

HIPAA

Providers must ensure the security of patients' protected health information (PHI) and adapt reasonable safeguards to protect PHI against unauthorized use and disclosure. PHI uses and disclosures are restricted to those related to treatment, payment, and healthcare operations. In addition, providers shall supply the Plan, CMS, or any other state or federal agencies with copies of patient medical records upon reasonable request.

No Plan Interference With Provider Advice to Patients

Members have the right to receive complete and accurate information from their providers about their medical care and to actively participate in the planning and decision-making process regarding their treatment.

Our Plan does not prohibit or otherwise restrict providers—acting within the lawful scope of their practice—from advising or advocating on behalf of members regarding:

- Their health status, medical care, or available treatment options, including self-administered alternatives;
- The risks, benefits, and possible outcomes of treatment or non-treatment; and
- The right to refuse treatment and to express preferences concerning future care decisions

Providers are responsible for ensuring that all information is presented in a way that is easily understandable to members. Members must be fully informed about all appropriate and medically necessary treatment options for their condition, regardless of cost or whether the Plan covers them. This includes information about available Medication Management Treatment Programs and any associated risks.

Provider Participation Standards Continued

Medical Record Documentation Standards & Maintenance of Beneficiary Records

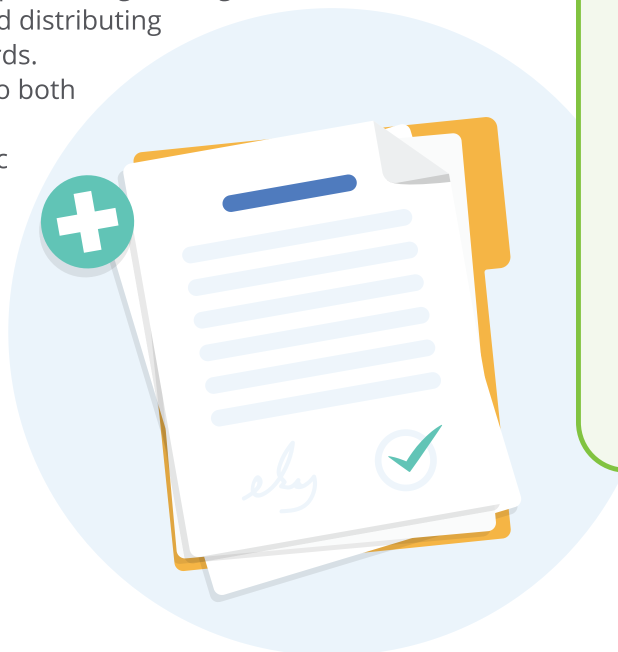
Participating providers are required to maintain complete medical, financial, and administrative records for all services rendered to Plan members, consistent with standard business practices. These records must be retained in accordance with all applicable federal and state laws and regulations, and for no less than ten (10) years from the date of service.

During the term of the provider agreement and for ten (10) years thereafter, the Plan, as well as authorized state and federal agencies, may review records related to services provided to plan members. Such access will be granted during normal business hours with reasonable advance notice.

In compliance with state and federal regulations, including those applicable to Medicare, providers must maintain medical records in a format that supports the evaluation of service quality, appropriateness, and timeliness as outlined in the provider agreement.

All patient medical records must be current and maintained in accordance with HIPAA privacy requirements and document retention standards. Records must be stored securely, with access limited to authorized personnel. Member information must be kept confidential, and patients have the right to approve or refuse the release of their medical records as required by law.

Providers must utilize a clinical record system capable of accurately processing, storing, retrieving, and distributing medical records. This applies to both paper-based and electronic systems.



Medical documentation must reflect consistent and accurate entries that demonstrate alignment between diagnoses, treatments, assessments, referrals, therapies, and follow-up care. Each member's medical record must include the following:

- Member identification information
- Names of all providers involved in the member's care and services rendered
- Documentation of significant medical and psychological conditions
- Presenting complaints, diagnoses, and treatment plans
- Medication records, including prescribed dosages, refill dates, over-the-counter products, and supplements
- Allergy and adverse reaction information
- Medical history, physical examinations, treatments, and risk factors
- Immunization history
- Laboratory, radiology, and other diagnostic test results
- Power of Attorney preferences
- Advance directive documentation, if available
- Health education and wellness services accessed
- Notations of significant medical advice provided by phone, including after-hours triage or information services

Unless otherwise specified in the provider agreement, the Plan retains the right to request and access medical records for purposes such as claims processing, quality of care reviews, coordination of care, utilization management, and compliance with CMS, state, or federal audits.

Provider Participation Standards Continued

Anti-Discrimination & Cultural Competency

Commitment to Health Equity, Non-Discrimination, and Cultural Competency

The Centers for Medicare & Medicaid Services (CMS) defines health equity as, “the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.”

As a participating provider, you play a vital role in advancing health equity and ensuring that all Plan members receive fair, respectful, and inclusive care.

Non-Discrimination Requirements

Participating providers are prohibited from discriminating against Plan members and must deliver services in accordance with the benefits covered under the member’s Plan—without regard to:

- English language proficiency or reading level
- Ethnic, cultural, racial, or religious background
- Mental or physical disabilities
- Sexual orientation or gender identity
- Socioeconomic or financial status
- Claims history or medical background
- Evidence of insurability (including conditions related to domestic violence)
- Genetic information
- Source of payment
- Any other basis prohibited by federal, state, or local law

Culturally Competent Care

Providers are required to ensure that all treatment information is communicated in a culturally competent manner. This includes:

- Presenting all treatment options, including the option of no treatment
- Providing meaningful access to individuals with disabilities through effective communication
- Ensuring accessibility across all points of care within the health system

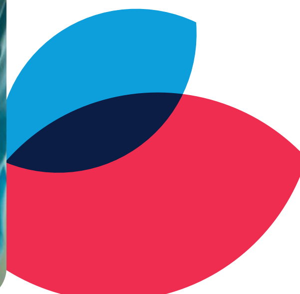
Interpreter and Teletypewriter (TTY) Services

If Plan members require assistance with communication—such as interpreter services or TTY access—they should be directed to contact the Member Services Department, which can also support members with facility accessibility concerns (e.g., wheelchair access).

Cultural Competency Training Resources

To support providers in delivering culturally responsive care, we encourage you to explore resources available through the U.S. Department of Health and Human Services Office of Minority Health. Their website offers training modules, best practices, and guidance on cultural and linguistic competency:

Cultural and Linguistic Competency | Office of Minority Health



Provider Participation Standards Continued

Member Rights and Responsiblities

All participating providers are required to respect and uphold the following member rights and responsibilities. These rights are designed to ensure that all Plan members receive equitable, respectful, and informed care.

Member Rights

Plan members have the right to:

- Provide Advance Medical Directives
- Receive information about their health plan, covered services, and providers
- Be treated with dignity, respect, and consideration at all times
- Privacy and confidentiality regarding their medical records and care
- Access participating providers and receive medically necessary covered services, including timely prescription fulfillment
- Participate fully in decisions related to their health care, including the right to refuse treatment
- Obtain accurate and complete information about their health and treatment options, including alternatives and potential outcomes, regardless of benefit coverage limitations
- Receive medical advice and treatment recommendations from their providers that are in their best interest, free from plan interference
- Have access to and be informed about Advance Medical Directives
- File complaints, grievances, or appeals without fear of retaliation and have those concerns addressed in a timely and fair manner
- Change primary care providers or specialists within the Plan network
- Decline participation in experimental or research-based treatments
- Request and receive interpreter or translation services, including teletypewriter (TTY) access, when needed to communicate effectively
- Request information about provider qualifications and verify malpractice coverage

Member Responsibilities

Plan members are expected to:

- Understand their health plan coverage, including benefits, limitations, and any rules for accessing care
- Use network providers for covered services, except in emergencies or when authorized by the Plan
- Present their current member ID card when seeking services and inform providers of their Plan enrollment
- Provide accurate and complete information to their providers to support appropriate diagnosis and treatment
- Promptly pay any applicable premiums, copayments, or cost-sharing amounts
- Notify the Plan and providers of changes to their address, phone number, or other contact information
- Communicate any questions, concerns, or dissatisfaction with services, coverage, or care to the Plan or provider
- Be respectful of providers, office staff, and other patients.

Provider Participation Standards Continued

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.

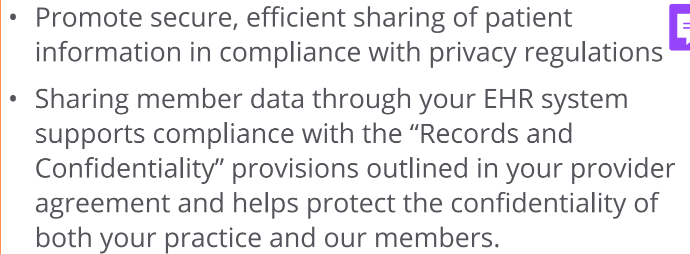
Connect Us to Your Electronic Health Records (EHR)

As part of our ongoing commitment to streamlining electronic interactions with our provider partners, we are seeking your support in establishing a connection to your Electronic Health Records (EHR) system.

Our objective is to enhance the exchange of clinical information between your practice and our Utilization Management (UM) department. By enabling direct EHR access, we aim to reduce administrative burdens related to medical record requests for care coordination and prior authorization processes, while also improving member outcomes.

Establishing this connection will:

- Facilitate faster turnaround times for medical reviews
- Reduce unnecessary authorization denials due to incomplete documentation



- Promote secure, efficient sharing of patient information in compliance with privacy regulations
- Sharing member data through your EHR system supports compliance with the “Records and Confidentiality” provisions outlined in your provider agreement and helps protect the confidentiality of both your practice and our members.

To initiate this process, please send the information below to: **uminquiryrequest@alignseniorcare.com**

- Practice Name
- Tax ID
- Primary Contact Name
- Phone Number
- Email Address

Once we receive your information, a member of our team will contact you to begin the setup process. We look forward to working together to simplify health record sharing and enhance care coordination for our members.

Access & Availability Standards

To guarantee that plan members receive timely care, the Plan has implemented comprehensive written access and availability standards for participating providers. These standards encompass routine, urgent, preventative, and emergent services. Providers must adhere to these access standards, which are detailed in the Provider Manual, to maintain their participation in the Plan. Compliance with these standards is assessed annually through the Access and Availability Survey, which is distributed to providers. Your participation in this survey is highly encouraged.

Marketing Activities in Healthcare Settings – CMS Compliance Reminder

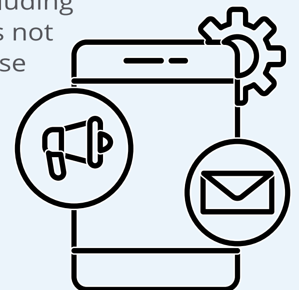
Participating providers must adhere to Centers for Medicare & Medicaid Services (CMS) regulations regarding marketing and patient outreach activities in healthcare settings. The Provider Manual outlines specific guidance to ensure providers understand what is permissible.

Providers cannot:

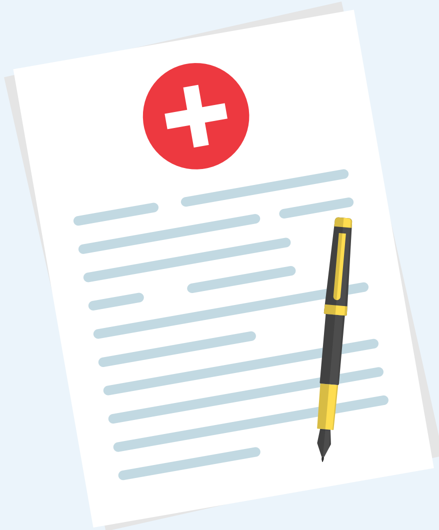
- Direct or attempt to steer an undecided potential enrollee toward a specific plan
- Limit a beneficiary’s options to a select number of plans based on the financial interests of the provider, agent, or organization
- Engage in marketing activities that could be perceived as coercive, misleading, or biased

Providers must remain neutral and impartial when discussing plan options or assisting beneficiaries with enrollment decisions

For comprehensive details on CMS-compliant marketing practices, including what is and is not allowed, please refer to the Provider Manual.



Provider Participation Standards Continued



Advance Directives

Plan members have the **right to participate in decisions about their healthcare, including the right to create and enforce Advance Directives—**such as instructions to withhold resuscitative measures or decline/withdraw life-sustaining treatment.

As a participating provider, you are prohibited from conditioning the provision of care or discriminating against a member based on whether they have executed an advance directive.

When delivering services, you should request a copy of the member's advance directive for inclusion in their medical record. This ensures that the member's healthcare preferences are documented and respected.

If you are unable to honor a member's advance directive due to a conscientious objection, you are required to promptly inform both the member and the Plan. The Plan will coordinate with you to ensure a safe and appropriate transfer of care.

For additional guidance, please refer to the Advance Directives section of the **Provider Manual**.

Transplant Network

Our Plan partners with Optum to provide plan members access to quality transplant providers. Optum's Centers of Excellence (COE)s deliver broad access, choice, and exceptional value. Our goal is to partner with Optum and network providers to reduce unnecessary procedures, improve the quality of transplant procedures, and improve the overall transplant customer experience. If you are interested in joining Optum's COE network of providers, visit their website at **www.optum.com**

Provider Satisfaction Survey Results

Your Voice Matters – Help Us Improve Provider Support

We are committed to fair and inclusive practices. We do not discriminate in terms of participation or reimbursement against any healthcare professional who is licensed or certified under applicable state law and operating within their scope of practice—regardless of the populations they serve. We deeply value our ongoing partnership with our provider community and actively seek your input to strengthen our services.

As part of our efforts to enhance the provider experience, we conducted an online Provider Satisfaction Survey in 2024, distributed through the emailed newsletter. While we received some valuable responses, the overall participation level was insufficient to generate a statistically valid sample.

We're asking for your participation this year to help shape meaningful improvements. Your feedback directly influences our strategic planning and helps us better support your practice and the members you serve.

Please take a few moments to share your insights with us. Your voice makes a difference. Thank you for your continued partnership and commitment to quality care.

https://forms.office.com/r/QQMkKBWBDk