What is SNIP level validation?

Cigna-HealthSpring implemented SNIP level 1-7 validation edits and began rejecting claims and encounters that did not comply with HIPAA ASC X 12 version 5010 implementation guidelines that started on August 15th. Today these exceptions/rejections are being communicated as “Warnings” on rejection reports to clearinghouses and providers.

This is necessary to improve data quality in CMS submissions by ensuring claims meet the SNIP level technical specifications before being processed through Cigna-HealthSpring’s adjudication system.

Your billing office or clearinghouse must correct the claim before resubmitting.

What is HIPAA ASC X12 5010?

› HIPAA ASC X12 version 5010 and NCPDP version D.0 are the current sets of standards regulating electronic transmission of specific health care transactions, including eligibility, claim status, referrals, claims and remittances.

› Use of the 5010 version of ASC X12 and the NCPDP D.0 standard is required by federal law.

› What does “SNIP Level Validation” mean? The Workgroup for Electronic Data Interchange (WEDI) was formed by the Secretary of Health and Human Services (HHS) and was named in the HIPAA legislation as an advisor to HHS. The Strategic National Implementation Process (SNIP) is a WEDI project that collaboratively developed the industry standard testing levels to validate compliance with HIPAA.

continued on page 2
What is SNIP level validation (cont.)

› There are seven levels of SNIP Level Validation
  Level 1: EDI syntax integrity testing
  Level 2: HIPAA syntactical requirement testing
  Level 3: Balancing
  Level 4: Situation testing
  Level 5: External code set testing
  Level 6: Product type or line of services
  Level 7: Implementation Guide-Specific Trading Partners

How do I know if my claims are processing?

› If you’ve received a remittance advice or explanation of payment (EOP) from Cigna-HealthSpring, then your claim has met specifications and has been adjudicated.

› If you file electronically, your claims may be sent to your clearinghouse, but may NOT have been received by Cigna-HealthSpring. Therefore, it is imperative to check the daily Rejection Report from your clearinghouse for any claims that may not have been accepted by your clearinghouse, Cigna-HealthSpring’s clearinghouse or Cigna-HealthSpring direct.

› If you are unsure about your Electronic Data Interchange (EDI) claims activity, contact your clearinghouse first to verify claims are being transmitted correctly.

What’s next?

You received a letter specifically announcing the implementation date of August 15th for this change. Please work with your clearinghouse or billing department to ensure data submitted to Cigna-HealthSpring is compliant as soon as possible. Until then, please refer all questions to your Network Operations representative.

Special Needs Plans

Model of Care Provider Training

Cigna-HealthSpring offers Medicare Advantage Special Needs Plans (SNP) designed for customers with special health care needs. The Centers for Medicare & Medicaid Services requires that the Health Plan make SNP Model of Care Training available for all contracted providers. To learn more about the SNP Model of Care Training, go to:


Call your local Network Operations Representative if you have questions or need assistance.
Access to care is important

Let’s keep our standards high across the board

Primary Care Physicians must have their primary office open to receive Cigna-HealthSpring customers for five days and at least 20 hours per week. In addition, and when medically necessary, the PCP must ensure that coverage is available 24 hours a day, seven days a week. Offices must be able to schedule appointments for Cigna-HealthSpring customers at least two months in advance of appointment. PCP’s must arrange coverage during absences with another Cigna-HealthSpring participating provider in an appropriate specialty documented on the Provider Application and agreed upon in the Provider Agreement.

<table>
<thead>
<tr>
<th>Appointment type</th>
<th>Primary care access standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent/Emergent</td>
<td>Immediately</td>
</tr>
<tr>
<td>Non-urgent/non-emergent</td>
<td>Within one week</td>
</tr>
<tr>
<td>Routine and preventive</td>
<td>Within 30 business days</td>
</tr>
<tr>
<td>On-call response (after hours)</td>
<td>Within 30 minutes for emergency</td>
</tr>
<tr>
<td>Waiting time in office</td>
<td>30 minutes or less</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Appointment type</th>
<th>Specialty care access standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent/Emergent</td>
<td>Immediately</td>
</tr>
<tr>
<td>Non-Urgent/non-emergent</td>
<td>Within one week</td>
</tr>
<tr>
<td>Elective</td>
<td>Within 30 days</td>
</tr>
<tr>
<td>High index of suspicion of malignancy</td>
<td>Less than seven days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Appointment type</th>
<th>Behavioral health access standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency and non-life threatening</td>
<td>Within 6 hours of referral</td>
</tr>
<tr>
<td>Urgent/symptomatic</td>
<td>Within 48 hours of referral</td>
</tr>
<tr>
<td>Routine</td>
<td>Within 10 business days of referral*</td>
</tr>
<tr>
<td>Waiting time in office</td>
<td>30 minutes or less</td>
</tr>
</tbody>
</table>

After-hours access standards

All participating providers must return phone calls related to medical issues. Emergency calls must be returned within 30 minutes. Non-emergency calls should be returned within 24 hours. A reliable 24/7 answering service with a beeper or paging system and on-call coverage arranged with another participating provider of the same specialty is preferred.
Medical record documentation

Standards checklist
Let's work together to make sure your customer medical records include:

- Identifying customer information
- Identification of providers participating in care and information on services furnished by these providers
- A problem list, including significant illnesses and medical and psychological conditions
- Presenting complaints, diagnoses and treatment plans
- Prescribed medications, including dosages and dates of initial or refill prescriptions
- Information on allergies and adverse reactions (or a note that patient has no known allergies or history of adverse reactions)
- Information on advanced directives
- Past medical history, including physical examinations, necessary treatments and risk factors relevant to the particular treatment

IMPORTANT: Cigna-HealthSpring may conduct site visits to determine whether the site conforms to the organization's standards for medical record keeping practices and the confidentiality requirements.

Let's work together toward better health

We respect your role
Medicare Advantage organizations may not prohibit or restrict health care professionals acting within the lawful scope of practice from advocating or advising patients about:

- Health status, medical care and treatment options including:
  - Alternative treatments that may be self-administered
  - Sufficient information to help individuals decide among all treatment options
- Risks, benefits and consequences of treatment or non-treatment
- Opportunity for patient to refuse treatment and express preferences about future treatments

Adoption and distribution of guidelines
Cigna-HealthSpring has adopted evidence-based clinical practice guidelines as road maps for health care decision-making targeting specific clinical circumstances. Cigna-HealthSpring promotes the use of clinical practice guidelines to:

- Define clear goals of care based on the best available scientific evidence
- Reduce variation in care and outcomes
- Provide a more rational basis for clinical management of some conditions
- Comply with accreditation standards and regulatory expectations

The link below will navigate to the clinical practice guidelines approved by Cigna-HealthSpring’s Clinical Guidelines Steering Committee:

cigna.com/iwov-resources/medicare-2016/docs/provider-manual клинических руководств.pdf
Advance Directives

**Five-step guide to the right process**

Cigna-HealthSpring supports a customer’s - or authorized representative’s - right to help make decisions about withholding resuscitative services or declining/withdrawing life-sustaining treatment.

Through education about Advance Directives, customers are encouraged to communicate their health care preferences upon enrollment, during the admission to a facility, and during checkups.

**IMPORTANT:** In accordance with Federal and State Law, Cigna-HealthSpring requires all participating providers to have a process in place pursuant to the Patient Self-Determination Act, including any conscientious objections to implementation of Advance Directives.

1. Inquire whether the customer has an Advance Directive or interest in obtaining information about Advance Directives.

2. Provide information on Advance Directives.

3. Provide information regarding customer’s right to appeal the provider’s decision not to implement the customer’s wishes as specified in the Advance Directive.

4. The provider must document whether or not the customer has executed an Advance Directive in a prominent part of the medical record.

5. Documentation of discussion of a living will or Advance Directive or provision of Advance Directive information will be a criterion for evaluation of medical care through medical record review.

Any complaints concerning non-compliance with the Advance Directive requirements may be filed with the State Survey and Certification Agency. Providers may not discriminate against a customer based on whether or not the customer has executed an Advance Directive. Cigna-HealthSpring and its providers are not required to provide care that conflicts with an Advance Directive.

---

**How to contract with Cigna-HealthSpring**

**Important anti-discrimination notice**

1. Any health care provider wishing to contract with Cigna-HealthSpring may submit an interest form located on the Cigna-HealthSpring website.

2. Cigna-HealthSpring reviews all interest forms and accepts or denies the request based on a needs assessment related to the provider’s specialty.

3. Should a provider be denied participation, a written notice is provided outlining the reasoning behind the denial.

**IMPORTANT:** No health care professional shall be discriminated against by Cigna-HealthSpring in reimbursement, participation or based on the population served.
Recognizing and treating older adults with depression

**Depression Disease Management Program**

Cigna-HealthSpring’s Depression Disease Management Program (DDMP) was developed to help customers suffering from depression by providing **support, education** and **care coordination**.

Our goal is to decrease the symptoms of depression for 20% of the customers enrolled in DDMP. This will be measured by an enrollment Patient Health Questionnaire-9 (PHQ9), completion of the DDMP and an exit PHQ9.

Enrollment in the DDMP can be by self-enrollment or physician referral. Cigna-HealthSpring will send information about depression and the DDMP to the customers.

› Customers are stratified using the PHQ9. Customers with mild levels of depression receive 12 weekly mailings with educational material about depression, symptoms, treatment, etc. and a call at the end of the 12 weeks to assess depression level.

› Customers with moderate levels of depression are sent a booklet at the beginning of the program and are supplemented with bi-monthly phone calls to provide support and educational information.

› Customers with severe levels of depression are referred to our Community Based Care Coordination team for more intensive intervention and follow up.

› The customer’s primary care physician is notified when the customer is enrolled in the program, if there are any changes in program level and at the end of the program.
### Know the rules of engagement

<table>
<thead>
<tr>
<th>Providers may:</th>
<th>Providers cannot:</th>
</tr>
</thead>
<tbody>
<tr>
<td>› Provide acceptable assistance to patients inquiring about Medicare plans but must remain neutral.</td>
<td>› Offer scope of appointment forms</td>
</tr>
<tr>
<td>› Accept marketing materials from Cigna-HealthSpring but must also accept materials from all other Medicare Advantage Organizations with which they participate.</td>
<td>› Accept Medicare enrollment applications</td>
</tr>
<tr>
<td></td>
<td>› Make phone calls or direct, urge or attempt to persuade beneficiaries to enroll in a specific plan based on financial or any other interests of the provider</td>
</tr>
<tr>
<td></td>
<td>› Mail marketing materials on behalf of plan sponsors</td>
</tr>
<tr>
<td></td>
<td>› Offer anything of value to induce plan enrollees to select them as their provider</td>
</tr>
<tr>
<td></td>
<td>› Offer inducements to persuade beneficiaries to enroll in a particular plan or organization</td>
</tr>
<tr>
<td></td>
<td>› Conduct health screenings as a marketing activity</td>
</tr>
<tr>
<td></td>
<td>› Accept compensation directly or indirectly from the plan for beneficiary enrollment activities.</td>
</tr>
<tr>
<td></td>
<td>› Distribute materials/applications within an exam room setting</td>
</tr>
</tbody>
</table>

**NOTE:** Cigna-HealthSpring will not distribute printed information comparing benefits of different health plans to providers or provider groups unless the materials have prior approval from CMS and Compliance in accordance with current Medicare marketing guidance.

### Services provided with cultural competence and language service

Participating providers must provide covered services in a culturally competent manner to all customers by making a particular effort to ensure those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities receive the health care to which they are entitled. Examples of how a provider can meet these requirements include but are not limited to translator services, interpreter services, teletypewriters or TTY (text telephone or teletypewriter phone) connection.

Cigna-HealthSpring offers interpreter services and other accommodations for the hearing-impaired. Translator services are made available for non-English speaking or Limited English Proficient (LEP) customers. Providers can call Cigna-HealthSpring customer service at **1-866-487-4331** to assist with translator and TTY services if these services are not available in their office location.
Practice changes

What to report – and why

Help us make sure we have your practice information correct and up-to-date. Timely reporting of changes in your practice helps in two important ways:

1. Ensures your listing is correct in the Provider Directory
2. Avoids potential claims denials for your physicians and you

Please contact your Network Operations representative to report any of the following changes:

1. Practice address
2. Billing address
3. Fax or phone number
4. Hospital affiliations
5. Practice name
6. Providers joining or leaving the practice (including retirement or death)
7. Provider taking a leave of absence
8. Practice mergers and/or acquisitions
9. Adding or closing a practice location
10. Tax Identification Number (please include W-9 form)
11. NPI number changes and additions
12. Changes in practice office hours, practice limitations, or gender limitations

Important: Please provide written notice of practice changes to Cigna-HealthSpring no less than 90 days in advance. If 90 days advance notice is not feasible, please inform us as soon as possible.

Provider Data Validation (PDV) team contact list

<table>
<thead>
<tr>
<th>Market</th>
<th>Email</th>
<th>Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>TN NWGA KC</td>
<td><a href="mailto:TNDocs@healthspring.com">TNDocs@healthspring.com</a></td>
<td>855-595-2211/860-907-8933</td>
</tr>
<tr>
<td>IL MA IL MMAI IL ICP IN TX MMP TX STAR+PLUS</td>
<td><a href="mailto:ProviderDataValidation@healthspring.com">ProviderDataValidation@healthspring.com</a></td>
<td>877-440-9336</td>
</tr>
<tr>
<td>AL GA NFL SMS NC SC</td>
<td>ALPDVT <a href="mailto:eam@healthspring.com">eam@healthspring.com</a></td>
<td>877-720-3859</td>
</tr>
<tr>
<td>TX MA</td>
<td>TX_PDV_T <a href="mailto:eam@healthspring.com">eam@healthspring.com</a></td>
<td>855-694-2717</td>
</tr>
<tr>
<td>MD DC DE PA</td>
<td>MAPA_PDV_T <a href="mailto:eam@healthspring.com">eam@healthspring.com</a></td>
<td>866-790-8599</td>
</tr>
</tbody>
</table>
Retina screening for diabetes

**American Diabetes Association Guidelines**

The American Diabetes Association (ADA) recommends patients with diabetes receive regular screenings for retinopathy with an ophthalmologist or optometrist.

### Retina screenings

<table>
<thead>
<tr>
<th>Patients who have</th>
<th>Diabetes prognosis</th>
<th>Dilated and comprehensive eye exam should be conducted</th>
<th>Subsequent eye exams should be conducted</th>
<th>Important notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Type 1</td>
<td></td>
<td>Within five years of diagnosis</td>
<td>Yearly</td>
<td></td>
</tr>
<tr>
<td>Diabetes Type 2</td>
<td></td>
<td>Shortly after diagnosis</td>
<td>Yearly</td>
<td></td>
</tr>
<tr>
<td>Well-controlled</td>
<td>Diabetes Type 1 or Type 2</td>
<td>Follow guidelines above</td>
<td>Every two years if patient has had two normal exams</td>
<td></td>
</tr>
<tr>
<td>Diabetes and progressing retinopathy</td>
<td></td>
<td>To be determined based on initial diagnosis of retinopathy</td>
<td>To be determined by patient’s eye care professional but the ADA recommends “more frequently”</td>
<td></td>
</tr>
<tr>
<td>Diabetes and planning to get pregnant</td>
<td></td>
<td>Before conception</td>
<td>Every trimester and up to one year postpartum based on evidence or degree of retinopathy</td>
<td>Women who are planning for or are currently pregnant should be counseled on increased risk retinopathy progression associated with pregnancy</td>
</tr>
<tr>
<td>Diabetes and currently pregnant</td>
<td></td>
<td>In first trimester, or as soon as possible</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Aspire Health

Helping patients with palliative needs

We recognize that all too often you don't have the time and resources required to have complex medical conversations with your patients and their families and to provide patients with the home-based support they often need at any hour of the day. At Cigna-HealthSpring, we are proud to say that Aspire began its initial pilot with our patients in October 2013 to help provide an extra layer of support to your patients who are facing an advanced illness.

Each of Aspire’s physicians leads a team of palliative care experts such as: advance practice providers, registered nurses, social workers, and chaplains. These experts visit patients in their homes or in select specialty outpatient practices. Each practice is also supported by an office-based team of nurses, social workers, and community health workers, dedicated to providing the help your vulnerable patients need to navigate their illness in a complex health care system. Aspire providers will regularly call their patients to ensure that they, as well as the patients’ other physicians, are always up-to-date on medical conditions and major concerns. Aspire will try to anticipate problems before they occur so they can work with patients, their family, and their other physicians to prevent crises. However, when crises do occur, the Aspire team is on call 24/7 so they can respond to a crisis whether it occurs after hours, over the weekend or in the middle of the night.

Aspire first began seeing patients in Nashville, Tennessee then subsequently expanded to Memphis and Chattanooga thus providing coverage to most of Tennessee. Shortly thereafter Aspire opened in Birmingham, Houston and Rio Grande Valley, Texas. To date, Aspire provides service in eleven states and will soon add New York and Ohio. Aspire is led by CEO Brad Smith and CMO Andrew Lasher and has regional vice presidents and clinical directors who oversee the operations of multiple markets. The current active enrollment in Aspire for Cigna-HealthSpring is 2,267 patients with a cumulative total enrollment of 4,973 since launching the program.

Physicians benefits include:

› Having a trusted partner to provide care outside of your office to your patients who are facing a serious illness
› Saving you time and money by providing additional support for some of your practice’s most complex and time-intensive patients, allowing you to see a higher volume of patients than would otherwise be possible
› Improved information about your patient’s health status between visits
› Reduced hospitalizations and improved clinical outcomes for some of your sickest patients

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>18.20%</td>
</tr>
<tr>
<td>CHF/Cardiac</td>
<td>31.38%</td>
</tr>
<tr>
<td>COPD</td>
<td>17.51%</td>
</tr>
<tr>
<td>CVA</td>
<td>2.83%</td>
</tr>
<tr>
<td>Debility</td>
<td>5.53%</td>
</tr>
<tr>
<td>Dementia</td>
<td>11.61%</td>
</tr>
<tr>
<td>ESLD</td>
<td>0.89%</td>
</tr>
<tr>
<td>Kidney Disease</td>
<td>7.85%</td>
</tr>
<tr>
<td>Other</td>
<td>4.19%</td>
</tr>
</tbody>
</table>

Diagnoses of Aspire patients

<table>
<thead>
<tr>
<th>Reasons for Discharge</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deceased</td>
<td>15.34%</td>
</tr>
<tr>
<td>Hospice</td>
<td>40.17%</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>6.25%</td>
</tr>
<tr>
<td>Insurance Change</td>
<td>2.70%</td>
</tr>
<tr>
<td>Other</td>
<td>3.51%</td>
</tr>
<tr>
<td>Outside Service Area</td>
<td>1.66%</td>
</tr>
<tr>
<td>Patient/Family Declined</td>
<td>10.75%</td>
</tr>
<tr>
<td>Physician Declined</td>
<td>1.63%</td>
</tr>
<tr>
<td>Stable</td>
<td>14.71%</td>
</tr>
<tr>
<td>Unable to Contact</td>
<td>3.29%</td>
</tr>
</tbody>
</table>

Final Disposition of Aspire patients
Disease-specific training schedule

Cigna-HealthSpring will host online disease-specific documentation and coding education meetings during 2016. These sessions are 15 to 30 minutes in duration. We have scheduled multiple dates and sessions to provide an opportunity for everyone to participate. Each session provides valuable insight about documenting and coding diseases more specifically. Clinicians, coding professionals and office administration staff are highly encouraged to attend. A question and answer session will follow each meeting.

<table>
<thead>
<tr>
<th>Date</th>
<th>Time CST</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/16/16</td>
<td>7 a.m.</td>
<td>HTN</td>
</tr>
<tr>
<td>08/16/16</td>
<td>11:30 a.m.</td>
<td>HTN</td>
</tr>
<tr>
<td>08/16/16</td>
<td>3 p.m.</td>
<td>HTN</td>
</tr>
<tr>
<td>09/20/16</td>
<td>7 a.m.</td>
<td>Z-Codes</td>
</tr>
<tr>
<td>09/20/16</td>
<td>11:30 a.m.</td>
<td>Z-Codes</td>
</tr>
<tr>
<td>09/20/16</td>
<td>3 p.m.</td>
<td>Z-Codes</td>
</tr>
<tr>
<td>10/18/16</td>
<td>7 a.m.</td>
<td>Rheumatoid Arthritis</td>
</tr>
<tr>
<td>10/18/16</td>
<td>11:30 a.m.</td>
<td>Rheumatoid Arthritis</td>
</tr>
</tbody>
</table>

All meeting conference codes are 3085470487

**Instructions to attend webinar:**

1. Go to the web link: [go.mc.iconf.net/fl/0oxz6bf](go.mc.iconf.net/fl/0oxz6bf)
2. Set up the audio by:
   a. Selecting “Dial-In Now” from the pop-up window that appears
   b. Using your phone call: **1-888-534-8066**
   c. When prompted, dial the conference code: **3085470487**
   d. Click “Join Meeting” to gain access to the presentation

All times are Central Standard Time (Eastern Standard Time is 1 hour ahead of Central Standard Time, Mountain Standard Time is 1 hour behind Central Standard Time)
ICD-10 coding tip reminders

› Use documentation language to ensure the highest level of specificity is ICD-10 code compatible
› Document laterality, organ sites, disease types, severity and dominance wherever applicable
› Avoid assigning non-specific ICD-10 codes whenever possible that could trigger a claim rejection

ICD-10 coding tables

<table>
<thead>
<tr>
<th>2016 Non-reversible dementia codes</th>
<th>2016 Reversible dementia codes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ICD-10-CM Code</strong></td>
<td><strong>ICD-10-CM Code</strong></td>
</tr>
<tr>
<td><strong>Description</strong></td>
<td><strong>Description</strong></td>
</tr>
<tr>
<td><strong>Definition / tips</strong></td>
<td><strong>Description</strong></td>
</tr>
<tr>
<td>G30.0</td>
<td>Alzheimer's disease with early onset</td>
</tr>
<tr>
<td>G30.1</td>
<td>Alzheimer's disease with late onset</td>
</tr>
<tr>
<td>G30.8</td>
<td>Other Alzheimer's disease</td>
</tr>
<tr>
<td>G30.9</td>
<td>Alzheimer's disease, unspecified</td>
</tr>
</tbody>
</table>
| G31.01 | Pick's Disease  
Primary progressive aphasia  
Progressive isolated aphasia  
G31.09 | Other Frontotemporal dementia  
Frontal Dementia  
G31.83 | Dementia with Lewy bodies  
Dementia with Parkinsonism  
Lewy body disease  
Lewy body dementia  
F01.50 | Vascular dementia without behavioral disturbance  
• Vascular dementia as a result of infarction of the brain due to vascular disease, including hypertensive cerebrovascular disease (includes arteriosclerotic dementia)  
• Code first the underlying physiological condition or sequelae of cerebrovascular disease |
| F01.51 | Vascular dementia with behavioral disturbance | F19.17 | Other psychoactive substance abuse with psychoactive substance-induced persisting dementia |

ICD-10 coding tip reminders

› Use documentation language to ensure the highest level of specificity is ICD-10 code compatible
› Document laterality, organ sites, disease types, severity and dominance wherever applicable
› Avoid assigning non-specific ICD-10 codes whenever possible that could trigger a claim rejection
Health outcomes survey (HOS)

What is HOS?
HOS is a Medicare survey of randomly selected customers designed to focus on each customer’s perception of his or her health and recollection of specific provider care delivered.

Why is HOS important?
HOS is part of HEDIS and directly affects Star Quality Ratings. Each year, Cigna-HealthSpring uses a CMS-approved vendor to administer the following two surveys:

- Baseline survey sent to a sample of eligible customers
- Follow-up survey sent to customers who completed the baseline survey two years prior to assess the customer’s health maintenance over the past two years.

How can providers affect HOS?
Providers can help improve satisfaction and perception of care by initiating conversations during routine checkups.

- Talk to your patient about:
  - The benefits of regular exercise
  - An exercise plan that is right for them
  - Tips on how to maintain a healthy weight
  - Choosing healthier foods
- Keep on the lookout for any warning signs of depression
  - Talk to your patient about how he/she feels
  - Ask if patient has experienced any loss of loved ones
  - Discuss if patient has had any changes in sleep patterns
  - Inquire if patient has lost interest in any activities they used to love
- Discuss patient falls or mobility challenges
  - Provide prompt treatment if needed
  - Provide safety tips to your patient
  - Instruct them on safety tips to prevent falling
Pharmacy update

60-Day formulary change notifications
Every month, the Preferred Drug List (formulary) is updated. Changes include but are not limited to removal of brand products, addition of new products including generics and removal/addition of UM restrictions such as quantity limit, step therapy, or prior authorizations. Information regarding changes may be found on our website at cigna.com/medicare/part-d/drug-list-formulary

60-Day notification for medical removal from formulary
When a medication is removed from the list, providers will be notified at least 60 days before it is removed, or if prior authorization, quantity limit or step therapy restrictions have been placed on a medication. This information will also be updated, along with any drugs added to the formulary, on our website at cigna.com/medicare/part-d/drug-list-formulary.

Formulary exception requests
Physicians may request exceptions to our coverage rules if medically necessary. Cigna-HealthSpring will make a determination within 72 hours after we receive the request from the physician. Formulary exception request forms are available on our website cigna.com/medicare/resources/2016-customer-forms and may be faxed to 1-866-845-7267.

Effective 3/1/2016

<table>
<thead>
<tr>
<th>Name of Affected Drug</th>
<th>Description of Change</th>
<th>Formulary Alternatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atropine Ophth 1%</td>
<td>Addition to formulary</td>
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</tr>
<tr>
<td>Molindone</td>
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<td></td>
</tr>
<tr>
<td>Dexilant</td>
<td>Addition to formulary with Step Therapy</td>
<td></td>
</tr>
<tr>
<td>Fenoprofen</td>
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</tr>
<tr>
<td>Empliciti</td>
<td>Addition to formulary with Prior Authorization</td>
<td></td>
</tr>
<tr>
<td>Ferriprox</td>
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</tr>
<tr>
<td>Zarxio</td>
<td>Addition to formulary with Prior Authorization</td>
<td></td>
</tr>
<tr>
<td>Ninlaro</td>
<td>Addition to formulary with Prior Authorization and Qty Limit</td>
<td></td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
<td>Esomeprazole</td>
<td>Addition of Step Therapy Criteria</td>
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</tr>
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</tr>
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Please refer to our website for a list of pharmaceuticals, which includes information on any restrictions, limitations, and preferences. Information on generic substitution, therapeutic interchange, and step therapy may also be found at cigna.com/medicare/part-d/drug-list-formulary.
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