providerNEWS

A Newsletter for **Freedom Health** & **Optimum HealthCare** Providers

FALL **2022**

IMPROVING 90-100-DAY SUPPLY PRESCRIPTIONS

Testing for Hemoglobin A1c

Quality Management Results Are In FRH-OPT

AND **much more!**

Printed and mailed 9/19/2022

CREDENTIALING CORNER

The Plan sends notification of re-credentialing by mail four months in advance of a providers scheduled re-credentialing due date.

The Plan Accepts CAQH Proview Credentialing applications.

When logging into the CAQH ProView Provider System to update or re-attest to your information, please review the informational banners used by CAQH to announce system updates and be sure to review the monthly ProView updates CAQH sends out via email.

Also, please continue to keep your credentialing application and attached documentation current in the CAQH Proview database. The following items are of importance in the credentialing process:

- **State Medical License(s) to include expiration dates**
- **DEA Certificate or protocol and reason for non-renewal if you chose not to renew your certificate**
- **Valid Insurance Information**
- **Practice locations**
- **Hospital Admitting privileges OR if you are a PCP and you do not have hospital admitting privileges, please ensure the Hospital Admitting Arrangements Supplemental Form is fully completed**
- **Partners/Covering Colleagues**
- **Questionnaire responses and explanations as required.**

For Providers Not Part of the CAQH Proview:

The notification cover letter specifies the steps and documents needed for re-credentialing, as well as the deadline for the submission of all current information.

Maintaining Active provider status is dependent upon completion of the re-credentialing process prior to the expiration date.

Thank you for your timely submission!

Please remember to notify the Plan promptly of any changes to your credentials.

EXCELLENCE IN CARE: Annual Assessments

Exceptional healthcare depends on comprehensive baseline exams which enable you to customize treatment for your patients. When you perform and document a yearly functional status assessment for those age 66 and older, you fulfill the standard of care as well as a HEDIS® performance measure *(Care for Older Adults: Functional Status Assessment).*

For many older patients, pain is a daily challenge. An annual pain assessment can capture the details of that pain and enable you to provide the right treatments and specialty referrals, if needed. Furthermore, assessing your patient's level of pain annually, provides an opportunity for you to observe any changes over time. This, too, will meet the standard of care and a HEDIS® measure *(Care for Older Adults: Pain Assessment).* Most importantly, it has the potential to greatly improve your patient's quality of life.

The best patient care starts with an astute assessment. Thank you for continuing to provide excellent primary care for your patients!

Medication Adherence

90-100 Day Prescription Strategies

5-STAR BEST PRACTICES

Part D Adherence Measures

- ✓ **Adherence for Diabetes Medications**
- ✓ **Adherence for Hypertension (RAS)**
- ✓ **Adherence for Cholesterol**

Refilling prescriptions can be a major obstacle to medication adherence for patients with chronic conditions. By prescribing 90-100-day supplies of medications to treat chronic diseases, you can help your patients increase adherence by reducing multiple pharmacy visits.

It's also essential for providers to make a conscious effort to deliver consistent and continual patient education and encouraging use of medication adherence aids (medication calendar, pill box, etc.) in addressing medication adherence.

Ways to Encourage Medication Adherence

Prescribe 90-100-day supplies for patients on adherence medications.

- Most adherence medications are Tier 1 with a $0 copay.
- Patients pay two copayments for a three-month supply for Tier 1, 2, and 3 medications using the Health Plan's mail order pharmacy (IngenioRx) or when filled at CVS.

Patient Understanding- Ensure your patients understand why you are prescribing the medications. Encourage your patients to speak with their pharmacist if they are unsure why the medication was prescribed to them.

Discuss barriers to adherence - Address your patients concerns about obstacles that might impede their ability to take medications as prescribed.

- **For patients with cost concerns:** Switching to Tier 1 formulary drugs and filling 90–100-day supplies can lower the prices patients pay for medications.
- **For patients who forget to refill prescriptions:** Encourage them to enroll in the automatic refill or refill reminder program at the pharmacy. Switching from 30-day to 90-100-day supplies will reduce the amount of pharmacy visits.
- **For patients who have difficulty getting to their pharmacy:** Encourage the use of the Health Plan's mail order delivery pharmacy, IngenioRx in addition to prescribing 90-100-day supplies.

[1]Steiner, et al. The effect of prescription size on acquisition of maintenance medications. J Gen Intern Med.1993; 8(6):3063-10.

Prescribing a 90-day or more supply of medication increased the likelihood that patients filled their prescriptions.[1]

Following up:

PCP Impact After an ER Visit or Observation Stay

The Plan's Model of Care and Population Health Strategy is based on the idea of the Patient-Centered Medical Home (PCMH). This care model gives our members the opportunity to be at the forefront of their care by collaborating with their Primary Care Physician (PCP) to help them reach and maintain their health care goals. Ideally, this relationship will promote a discussion and plan concerning unexpected occurrences such as ER visits and Observation stays and will encourage members to see their PCP within a short time afterwards. In times when the member does need to go to the emergency room or has an observation stay, please ensure they understand the importance of prompt PCP follow-up post visit for continuity of care and care coordination. Like ER visits, a timely PCP visit after an Observation stay may prevent future unnecessary use of urgent care services.

Adopting the PCMH Model Benefits the Provider

There has been plenty of data in the past decade attributing patient success to the PCMH approach. However, studies and research are also showing the positive impact it has on PCP practices. These notable outcomes have likely driven so many providers to adopt the PCMH model.

Let's explore a few examples of how PCMH recognition may benefit the health care provider.

- One of the cornerstones of PCMH is the relationship between the patient and their care team. Developing a relationship with the

patient fosters trust and improves quality of care. The result of this improved interaction can decrease no-show rates. This in turn can have a ***financial impact on the practice*** because no-shows take up time slots that cannot be billed.

- A requirement of gaining PCMH recognition is adhering to evidence-based guidelines. The aim is to increase use of recommended preventive care that can decrease unnecessary ER visits. As a result, patients receive whole person care, thereby increasing their level of satisfaction with the PCP. With that in mind, patients are likely to share their positive experience with family, friends, and social media which undoubtedly impacts the PCPs' reputation and can result in ***increased panel size*** for the PCP.
- Involving the entire care team is another important concept in the PCMH model. Every team member has a role when caring for the patient. This allocation of resources is especially beneficial to large practices since it frees up the PCP to focus on areas that require their high-level skills while their team handles the rest. With such protocols in place, PCP s have time to see more patients, thereby ***growing their practice***.

PCP Visits That Make the Difference

When a patient experiences a transition of care such as an ER visit or an Observation stay, the PCP is in a position to have the most significant impact on the patient's ability to stay out of the hospital. By employing another important standard of PCMH – making primary care accessible – the PCP remains available to determine whether a patient requires urgent, emergent or in-office care. The PCP is able to capitalize on the small window of opportunity to review the patient's immediate health needs and prevent unnecessary re-admission.

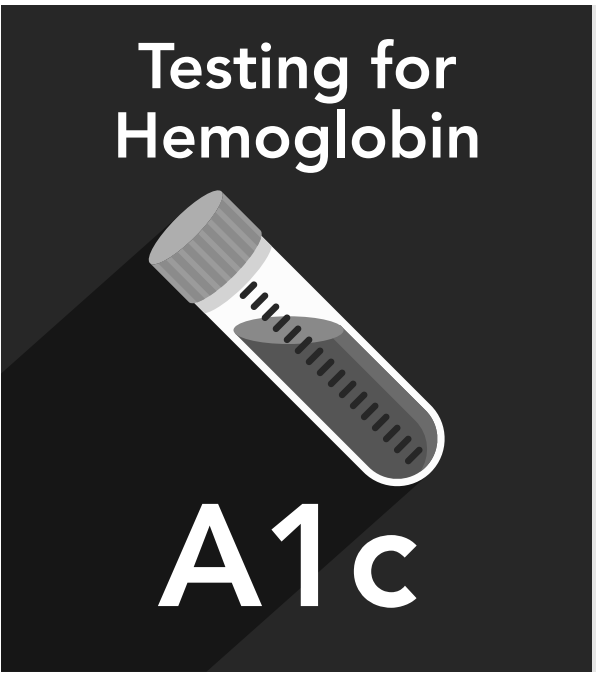
During this follow-up visit, the PCP can review with the patient any treatment plan or medication changes, make referrals to specialists and address barriers that can interfere with the healing process. This is a collaborative review, and the patient should be encouraged to ask questions. ***Observation stays, like ER visits, are warning signs that an illness or condition may need increased oversight.***

Providing members with PCP care team access 24/7 and same-day urgent appointments may help reduce ER and Observation visits. In addition, the Plan has a Nurse Advice Line staffed by nurses and available to members 24/7 (tel. 1-888-883-0710). There are no copays or deductibles for this benefit.

OUR GOAL

While the Health Plan encourages all members with ER visits and Observation stays to visit their PCP within 7 days of discharge from the ER, the Plan's goal for PCP follow-up within 30 days after an ER Visit is 65% and after an Observation stay is 65.3%. These goals are reviewed yearly and adjusted as necessary based upon national and internal benchmarks and historical performance.

The ultimate goal for both the Health Plan and the PCP is increasing access for members to primary care and helping them to see the PCMH as an ongoing relationship whereby, through collaboration, they can achieve maximal health and well-being and minimize emergent health issues.



Managing diabetes can be a difficult challenge. A healthy diet, medication plan, and a physician recommended exercise regimen can help keep your patient's disease under control. A good reference measure to have in your patient's chart is a history of their Hemoglobin A1c levels.

Consider informing your patients that a Hemoglobin A1c is a simple blood test that can provide an estimate of their average blood sugar over the past three months. Providing this information will help the patient to understand how their body handled its sugar intake and will help keep them informed and on track with their treatment plan.

Please consider ordering a Hemoglobin A1c as part of a routine work-up for any patient at risk of, or currently managing, diabetes. Encouraging patients to use the Plan's approved vendor, LabCorp, will ensure that the results get communicated without any additional effort.

YOUR QUALITY SCORES

The Plan strives to provide the best quality of care to its members and expects all providers who service our members to adhere to stringent Federal and State standards regarding documentation, confidentiality, maintenance and release of medical records, as well as personal health information (PHI).

The Plan's Provider Manual describes the medical record standards required for contracted providers. As a reminder, all providers must follow these standards and cooperate with the Plan in activities related to quality assurance monitoring of medical records. Meeting these requirements applies to both electronic and paper medical records.

Our Plan's goal for medical record documentation compliance is to consistently excel across the ten (10) components noted below. To meet NCQA Medical Records standards and accreditation, the Plan's Quality Management department uses these standards to conduct annual audits of sampled medical records and score network provider performance. Those components are:

1. The record is legible
2. Past medical history
3. History and physical
4. Allergies and adverse reactions
5. Problem list
6. Medication list
7. Working diagnoses and treatment plans
8. Unresolved problems
9. Documentation of clinical findings and evaluation
10. Preventive services and/or risk screening

2022 MRR Standard Component CY 2021 Freedom Health	Frequency of Total Survey
Is the record legible?	**100.0%**
Is there an appropriate past medical history in the record?	**100.0%**
Is the history & physical documented?	**99.6%**
Are allergies & adverse reactions to medications prominently displayed?	**99.8%**
Is there a completed problem list?	**98.7%**
Is there a medication list?	**35.4%**
Is there a working diagnosis(es) and treatment plan(s)?	**99.6%**
Are unresolved problems documented?	**98.7%**
Is there documentation of clinical findings and evaluation?	**58.4%**
Is there documentation of preventive services and/or risk screening?	**99.8%**

Mean overall component** ***89.0%

We require that providers maintain the utmost quality of medical record documentation and ask that you pay special attention to these ten standards in your future record-keeping practices. We are very proud of our providers. Almost all of the medical record standard components met the goal of 90 percent or greater compliance.

There were 160 providers whose records were reviewed which resulted in 2,888 medical records, in which the overall mean score was 89.0 percent of the total of the components, which is -1.0 percent below the internal benchmark. There were only two (2) individual components that did not meet the established 90% internal Health Plan benchmark, "Is there a medication list?" and "Is there documentation of clinical findings and evaluation?" which the frequency of the total surveys were 35.4 percent and 58.4 percent, respectively. As a result, these components scored lowest during evaluation and are therefore in need of improvement. Our goal is to educate our healthcare providers on meeting the performance goals for the 2022 Medical Record Standards Review process.

An accurate medication list and documentation of clinical findings and evaluation are necessary components in providing essential care. It is important that these items are continually updated as accuracy of these components provides a better care experience for individuals as well as better health for populations. Following the standards ensures that the Plan meets Medical Record Review requirements as well as helps with coordination of care and follow-up of patient's medical issues. If you have any further questions on these Medical Records Standards or results, please contact your Provider Relations Representative. For additional medical record criteria and documentation standards/ requirements for adherence, please refer to our Provider Manual. Download a copy from our websites:

https://www.freedomhealth.com/dlsecure/?_id=3023299

To request a paper copy of the Provider Manual, please contact your Provider Relations representative.

Medical Record Standards

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The Plan's Provider Manual describes the medical record standards required for contracted providers. As a reminder, all providers must follow these standards and cooperate with the Plan in activities related to quality assurance monitoring of medical records. Meeting these requirements applies to both electronic and paper medical records.

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1. The record is legible
2. Past medical history
3. History and physical
4. Allergies and adverse reactions
5. Problem list
6. Medication list
7. Working diagnoses and treatment plans
8. Unresolved problems
9. Documentation of clinical findings and evaluation
10. Preventive services and/or risk screening

We require that providers maintain the utmost quality of medical record documentation and ask that you pay special attention to these ten standards in your future record-keeping practices. We are very proud of our providers. Almost all ten (10) of the medical record standard components met the goal of 90 percent or greater compliance.

2022 MRR Standard Component CY 2021 Optimum HealthCare	Frequency of Total Survey
Is the record legible?	**100.0%**
Is there an appropriate past medical history in the record?	**89.9%**
Is the history & physical documented?	**90.7%**
Are allergies & adverse reactions to medications prominently displayed?	**94.3%**
Is there a completed problem list?	**10.6%**
Is there a medication list?	**99.0%**
Is there a working diagnosis(es) and treatment plan(s)?	**99.7%**
Are unresolved problems documented?	**51.7%**
Is there documentation of clinical findings and evaluation?	**93.5%**
Is there documentation of preventive services and/or risk screening?	**92.2%**

Mean overall component** ***82.2%

There were 364 providers whose records were reviewed which resulted in 2034 medical records, in which the overall mean score was 82.2 percent of the total of the components, which is -7.8 percent below the internal benchmark. There were only three (3) individual components that did not meet the established 90% internal Health Plan benchmark, "Is there an appropriate past medical history in the record?", "Is there a completed problem list?", and "Are unresolved problems documented?" in which the frequency of the total surveys were 89.9 percent, 10.6 percent, and 51.7 percent, respectively. As a result, these components scored lowest during evaluation and are therefore in need of improvement. Our goal is to educate our healthcare providers on meeting the performance goals for the 2022 Medical Record Standards Review process.

An accurate problem list is a necessary component in providing essential care. It is important that the problem list is continually updated as an accurate problems list provides a better care experience for individuals as well as better health for populations. In order to meet Medical Records Review standards, a completed problems list must be labeled as "Problem(s)" and include significant illnesses, medical conditions, health maintenance concerns and behavioral health issues noted in the medical record. Problem lists should also be reviewed to determine if a symptom or lab finding needs to be updated to a diagnosis. Another update would be resolving problems. Sometimes resolved problems may move to another section of the medical record such as past medical history or family history. In providing these updates, an unresolved problem list from a previous visit(s) are addressed to provide essential care. Unresolved problem lists should also be labeled "Unresolved Problem(s)" in order to meet Medical Records Review standards. Providers adhering to a complete and updated problem and unresolved problem list provide a snapshot of the patient's current diagnoses.

Following the standards ensures that the Plan meets Medical Record Review requirements as well as helps with coordination of care and follow-up of patient's medical issues. If you have any further questions on these Medical Records Standards or results, please contact your Provider Relations Representative. For additional medical record criteria and documentation standards/ requirements for adherence, please refer to our Provider Manual. Download a copy from our websites:

https://www.youroptimumhealthcare.com/dlsecure/?_id=5763214

To request a paper copy of the Provider Manual, please contact your Provider Relations representative.

PROTECTIONS AND ACCOUNTABILITY

Our Member's Rights and Responsibilities

Member Rights include those regarding Privacy and Security of our member's medical records, as per HIPAA. For example, members have a right to:

- **Receive an accounting of all disclosures of their personal information to third parties**
- **Receive a written summary or explanation of their health condition**
- **Review, copy, and amend incorrect data in their medical records**

We have also included member rights specific to Advance Directives. For example, no member shall be discriminated against for filing or not filing an Advance Directive. Members have a right to file an advance directive and have their wishes respected.

Freedom Health strongly endorses the rights of members as supported by State and Federal laws, NCQA, CMS and AHCA. The Plan regularly communicates its expectations of members to be responsible for certain aspects of the care and treatment they are offered and receive. In turn, Freedom requires that all of its providers acknowledge and reinforce our member's rights and responsibilities.

Please note: As a provider, you may deny a member access to their medical records if you believe it could endanger them or someone else's physical safety, for some psychotherapy notes, for information compiled for a lawsuit, or for certain other limited circumstances.

Please contact your Provider Relations representative if you have questions about this provision of the law. For a full list of Member Rights and Responsibilities, please refer to our websites at:

www.freedomhealth.com > About Us > Utilization & Quality > Member Rights and Responsibilities

www.youroptimumhealthcare.com >About Us > Utilization & Quality> Member Rights and Responsibilities

Quality Management:

Our goal is to help our members improve their health by providing the best care and service options. To do this, we rely on our Quality Management (QM) program to monitor the quality of care given by Plan providers. The QM Program also looks for areas of service that need to be improved.

Every year, we measure to see the progress we have made toward meeting our goals for healthy members. One of the tools we use to do this is called HEDIS®, which stands for **H**ealthcare **E**ffectiveness **D**ata and **I**nformation **S**et. HEDIS® is a very common tool used by health care plans to see how well they are serving their members. We use these HEDIS® results to see where we need to focus our improvement efforts.

Optimum Healthcare HEDIS® Results

Our HEDIS® MY 2021 results show that Optimum Healthcare ***improved its performance and met quality goals*** in many HEDIS® measures. These areas include:

- Colorectal Cancer Screening
- Controlling High Blood Pressure
- Comprehensive Diabetes Care: Blood Pressure Controlled <140/90 mm Hg
- Transition of Care: Medication Reconciliation Post- Discharge
- Persistent of Beta-Blocker Treatment After a Heart Attack
- Pharmacotherapy Management of COPD

Areas where ***we would like to improve our performance*** include:

- Osteoporosis Management in Women
- Use of High-Risk Medications in Older Adults
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD

Freedom Healthcare HEDIS® Results

Our HEDIS® MY 2021 results show that Freedom Health ***improved its performance and met quality goals*** in many HEDIS® measures. These areas include:

- Antidepressant Medication Management: Acute Phase Rx
- Antidepressant Medication Management: Continuation Phase Rx
- Colorectal Cancer Screening
- Comprehensive Diabetes Care: Blood Pressure Controlled <140/90 mm Hg
- Comprehensive Diabetes Care: Poor HbA1c Control > 9.0%
- Controlling High Blood Pressure
- Osteoporosis Management in Women
- Transition of Care: Medication Reconciliation Post- Discharge

Areas where ***we would like to improve our performance*** include:

- Comprehensive Diabetes Care: Eye Exams
- Comprehensive Diabetes Care: HbA1c Control < 8.0%
- Persistence of Beta-Blocker Treatment After a Heart Attack
- Follow-Up Hospital Mental Illness (30-Days and 7-Days)
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD

You can view our full quality Health Plan Report Card at: **https://reportcards.ncqa.org/health-plans**

For more information on HEDIS® and Performance Measurement, go to: **https://www.ncqa.org/hedis/**

"The Results are in!"

You can also call Optimum Healthcare Member Services at 1-866-245-5360 and Freedom Healthcare Member Services at 1-800-401-2740.

Find a full list of the Plan's HEDIS® results online at:

www.youroptimumhealthcare.com →About Us →Utilization & Quality → Quality Management→ Monitoring Quality

Find a full list of the Plan's HEDIS® results online at:

www.freedomhealth.com →About Us →Utilization & Quality → Quality Management→ Monitoring Quality

OMW – Osteoporosis Management in Women Who Had a Fracture

The percentage of women 67–85 years of age who suffered a fracture and had either a bone mineral density (BMD) test or was prescribed a medication to treat osteoporosis within the six months after the fracture.

***Note:** Fractures of the finger, toe, face, or skull are not included in this measure.*

Requirements:

Appropriate testing or treatment for osteoporosis after the fracture defined by any of the following criteria:

1. Bone Mineral Density Test in the six months after the fracture.
    a. Medical Record Documentation:
    i. Member Demographics: Patient first name, last name, and date of birth
    ii. Provider Demographics: Provider first and last name, legible signature & credentials
    iii. Type of bone mineral density test documented in the medical chart, test date, and results
        1. Within 24 months before and/or 6 months after the date of fracture
        2. Bone mineral density test report (DXA Scan/ Ultrasound/Computed Tomography)

2. Osteoporosis Medication Therapy - Dispensed prescription for osteoporosis medication within 12 months before or 6 months after the date of fracture
    a. Documentation of the patient's name, date of birth, medication name, dose, route, NDC code and date it was dispensed
    b. Picture of the patient's prescription bottle
    c. Pharmacy medication administration record/label showing evidence the medication was dispensed

Comprehensive Diabetes Care: Eye Exams

The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had a retinal eye exam.

Requirements:

- Retinal or dilated eye exam by an optometrist or ophthalmologist in measurement year 2022
- Negative retinal or dilated eye exam by an optometrist or ophthalmologist in 2021 (prior year)
- Bilateral eye enucleations any time during their history through Dec. 31, 2022

***Notes:** Unilateral eye enucleations still require the retinal or dilated eye exam as mentioned above for the remaining eye. Both diabetic retinopathy and hypertensive retinopathy are considered positive findings.*

Documentation/Submission:

- A note or letter prepared by an ophthalmologist, optometrist, primary care practitioner (PCP), or other healthcare professional indicating that an ophthalmologist or optometrist completed the exam, the date of the procedure, name of procedure and the results.
- Eye exam results read by a system that provides an artificial intelligence (AI) interpretation meet criteria.
- A photograph of retinal abnormalities indicating the date of the funduscopic photography and evidence that an eye care professional reviewed the results. Alternatively, a qualified reading center operating under the direction of a medical director (who is a retinal specialist) may read the results.
- Patient-reported services are acceptable if it is collected as part of the patient's history. It must indicate the date and result and that the test was performed or interpreted by an eye care professional documentation.
- Documentation of a negative retinal or dilated exam (negative for retinopathy) by an Ophthalmologist or Optometrist in the prior year (2021), meets the requirement for this screening.
- Evidence that the member had bilateral eye enucleation or acquired absence of both eyes. Look as far back as possible in the member's history through December 31, 2022.
- Blindness is not an exclusion.

Let's work together to continue our improvement of HEDIS® scores and our overall quality of care. Our goal is to deliver excellence in all our health care services!

References:

NCQA® HEDIS® Measurement Year 2022 Volume 2: Technical Specifications for Health Plans
Last Updated: 8/23/2022

Primary Care Physician (PCP) Related Grievances

As the masses return to normalcy in daily life during the post COVID era, so has the utilization of healthcare in all aspects of medicine. Members' transport, vision, and dental services have surpassed their pre-COVID utilization rates. As a correlation to utility, complaints inherently are back on the rise and as providers are the face of the plan with direct interaction with enrollees, we are faced with the challenge of providing great affordable care, speedy services, and exceptional care while having shortages in staffing, residual COVID sicknesses, and increased administrative protocols because of the pandemic. The health plan has found that satisfaction of the member populous is greatly dependent on the providers and staff that see them. Offering a level of care with a member centric approach would not only decrease these complaints, but also improve the overall rating of the plan and drive enrollment growth.

The Plan has found that primary care physician related complaints make up a major percentage of the total complaints received in 2022. Specifically, complaints related to not being provided referrals or authorizations, office staff being rude, phone wait times, all drive the complaints for the Primary Care Physician category. Now you may ask why would these matter to a PCP? For one, a happy member leads to better health overall and following treatment regimens greatly improving outcomes. Additionally, the secondary gain of receiving better feedback and ultimately, a better rating for the providers and the plan.

To lessen the volume of these types of complaints, the Plan recommends offering members additional time with either you as a provider, or an office staff, to review if all the members needs have been covered prior to ending their appointment. This has the added benefit of members tying up staff and phone lines for items that could have been resolved in the office. Also giving members clear and concise reasons for why you, as a provider, have chosen the treatment plan you have, assists in the member understanding why you haven't given them a referral to see a specialist or authorized a specific treatment. Incorporating these two simple steps undoubtedly have the benefits of improving the patient/doctor relationship as much as improving overall health, satisfaction, and well-being of the member population.

SNP Provider Education Available to Specialists

Medicare requires that physicians who treat Special Needs Plans (SNP) members undergo annual SNP training. We have a focused effort assuring training for our Primary Care Physicians (PCPs) facilitated by Provider Relations as our PCP's are our member's primary contact and medical home.

However, since provider care is a team approach and many of our member's routinely see Specialty providers, each doctor who routinely treats our SNP members is encouraged to complete the training and verify it through attestation. Upon review, physicians receive valuable information about the specialized needs of SNP members and our Health Plan's SNP Model of Care.

To access online training materials, please navigate to the Freedom Health & Optimum HealthCare SNP Provider Compliance Training website located below:

https://training.globalmedicareapps.com/Login/Login.aspx?Payer_Id=GLOBAL

You can also access the website by going to our Freedom Health or Optimum HealthCare Website, Providers > Tools and Resources > Compliance – Provider/Vendors Training Management System link.

Log in using your National Provider Identifier (NPI) to access the training materials.

If you prefer a paper version of the training material, please feel free to contact us at (813) 506-6000 Ext. 44002.

PROVIDER RELATIONS DEPARTMENT 2022

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Network Management Rep - Gym, Vision, Lab, Dental, Hearing, Trans, Chiro, Podiatry	Kenneth Daniels	(813) 506-6000	11417	kdaniels@freedomh.com
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Provider Network Manager II - PCPs for Citurs/Hernando	Kristen Doherty	(813) 506-6000	22060	kdoherty@freedomh.com
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Gulf Coast

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Central Florida

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Provider Network Mgr I - PCP/Complete Health IPA/ Specialists - Brevard and Volusia Counties	Jennifer Solano Lucas	(407) 965-2684	22117	jslucas@freedomh.com
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FREEDOM HEALTH

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provider NEWS

FALL 2022

IN THIS ISSUE

The Health Plan has a special program that is designed to help keep your patients healthy and avoid a hospital stay. The Centers for Medicare and Medicaid Chronic Care Improvement Project (CCIP) is a 3-year cyclical health plan requirement with a driving focus on improved health outcomes for our members with a chronic condition. Our CCIP focuses on reducing readmission rates for patients that have a CHF diagnosis. The CCIP has many valuable resources including Case Managers that are Registered Nurses, a Dietitian, Social Workers, and Care Coordinators that can help to arrange benefits like transportation and gym memberships. You can contact the Case Management Department for assistance in referring your patients to this program, there is no additional cost to participate and take advantage of these special resources. Staff are available Monday through Friday from 8:00AM to 4:00PM EST at 1-888-211-9913 or TTY/TDD 711.