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PROVIDER NEWS

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HEDIS Five Star Providers' Best Practices & Suggestions

Provider Relations recently contacted network providers who scored five stars in completion of HEDIS measures to obtain some best practice suggestions. After looking at the list of best practice recommendations, we compiled the most common suggestions below. This list is composed of providers' recommendations in an effort to improve member satisfaction with his/her PCP.

Almost universally, the 5-star providers recommended that PCPs and their office staffs build and maintain positive relationships with their patients and treat them like family. Providers found that by compiling small items like the names and ages of their patients' grandchildren and health status of the patients' family members in their medical records proved to be beneficial. This enabled PCPs and staff members to ask their patients about them and facilitated good communication and trust.

Another common recommendation was for PCPs to offer extended working hours and/or grant walk-in appointments for their patients with chronic illnesses. PCPs on the list generally felt that by spending at least 20 minutes with each patient (if possible), the encounter generated the best outcomes. This time could be spent by going over laboratory results, providing illness education, or answering questions. Also, nurses and medical assistants are valuable in PCPs' offices, but PCPs felt that patients generally preferred receiving time with their PCP. This typically made patients feel as though their health care plan was personalized.

The PCPs on the list also suggested timely follow-up with patients. A provider gave a suggestion of calling patients on the day after an office visit to ensure that all instructions were understood. This extra effort by the office staff creates a sense that the PCP and the office staff care about the member and his/her health. Also, PCPs' staff members who placed reminder calls to members in the days before a scheduled visit seemed to have the best results. Finally, PCPs with office staff where turnover is low generally have the greatest successes in creating a family-style environment where members can feel comfortable.

Credentialing Corner

How to ensure a smooth re-credentialing process

Re-credentialling is required every three years. Our ability to access your current and complete data from CAQH Proview will allow for a smooth and timely re-credentialing process. Please continue to update CAQH Proview with your credentialing information, including any related documentation.

For Providers Not Part of CAQH Proview

The plan sends notifications and re-credentialing applications by mail four months in advance of a provider's credentialing experiation date. 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.

Active provider status is dependent upon completion of the re-credentialing process prior to the three-year expiration date. Thank you for time submission.

Behavioral Health Care Tools to Assist in Sharing Information

We routinely collaborate with Beacon Health Options, our Health Plan's Behavioral Health vendor, to identify, facilitate and assess continuity & coordination between medical care and behavioral healthcare providers. Through that collaboration, we wanted to share the following resources that provide details and release of information tools that may help you in facilitating the exchange of information with our members:

- Behavioral Health Provider Manual and
- Web based PCP Toolkit

The Beacon Health Options Provider Manual is posted on Beacon's website, https://www.beaconhealthoptions.com/providers/forms-and-resources/

(scroll down page to Manuals) and the PCP Toolkit can be accessed through

http://pcptoolkit.beaconhealthoptions.com

Along with Beacon Health Options, we strongly encourage Primary Care Providers, Specialists and behavioral health providers to share relevant information regarding diagnoses, medication, and/or treatment to help improve health outcomes and continuously deliver quality care to our members.

Your Role In Care Transition Support

Do You Know When One of Your Patients is Admitted to a Hospital?

Our Health Plan is making a renewed effort to identify gaps in treatment and proactively resolve issues for members after a hospital stay. The goal is to remove barriers that prevent the member's plan of treatment from being implemented, while positively affecting readmission rates.

Did you know the Health Plan's staff makes Discharge Support calls to members shortly after their discharge?

Discharge support calls help us identify members who may be at risk for readmission. Our experienced staff is assessing:

- Whether discharge instructions are available and understood
- If the member's current support mechanisms are adequate, including psychosocial barrier resolution
- Medication compliance, e.g., prescriptions being filled and taken as prescribed
- Whether home health visits or Durable Medical Equipment have been scheduled or provided, when applicable.

How soon do you see a patient after their discharge from an acute care facility?

Members are encouraged to bring all discharge instructions to their follow-up PCP visit. If the member has not scheduled a follow-up appointment at the time of the Discharge Support call, the Health Plan staff facilitates the appointment scheduling with the PCPs office staff. The target is that the member has a follow-up PCP consult within seven days post-hospitalization.

Do you have a copy of the Discharge Summary?

With the growing use of hospitalists, the discharge summary serves as a communication tool and provides the basis for continuing care especially if you don't have access to all of the member's inpatient documentation. Both CMS and Hospital accreditors require a discharge summary documenting the patient's outcome of hospitalization, disposition and provisions for follow-up care. The Discharge Summary provides valuable information regarding the member's inpatient stay, treatment and medications. Providers are encouraged to actively seek this information to provide appropriate follow-up care and prevent readmission.

What's the Fuss About the Diabetes Subterm "With"?

The Diabetes subterm "with" should be interpreted as a link between diabetes and any of those conditions indented under the word "with" in the ICD-10 Alphabetic Index. New ICD-10 guidelines clarify the physician documentation does not need to provide a link between the diagnosis of Diabetes and a condition listed under subterm "with" found within the ICD-10 Alphabetic Index.

For example, if the physician's Assessment states

- Diabetes Type 2
- Polyneuropathy

The correct code assignment is E11.42, Type 2 Diabetes Mellitus with Diabetic Polyneuropathy. Although there is no linking verbiage documented in the medical record, Polyneuropathy is listed under Diabetes subterm "with" in the Alphabetic Index. Since Polyneuropathy is not documented as due to some other condition, the coder can assume a causal relationship between the conditions.

These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated and due to some other underlying cause besides diabetes. For conditions not specifically linked by these relational terms in the classification, provider documentation must link the conditions in order to code them as related.

For example, if the physician's Assessment states

- Diabetes Type 2
- Cellulitis

The correct code assignment is E11.9, Type 2 Diabetes Mellitus without Complications and L03.90, Cellulitis unspecified. In this case, there is no linking verbiage documented and Cellulitis is not listed under Diabetes Index subterm "with." Do not assign code E11.628 Diabetes with Skin Complication NEC (The specific complication must be documented as linked to Diabetes). Do not assume a causal relationship.

The relationship between Diabetes and any condition not found listed under the subterm "with" in the ICD-10 Alphabetic Index must be clearly documented to be coded as a diabetic complication.

IMPORTANT NOTE

The "with" guideline does not apply to "Not Elsewhere Classified (NEC)" Index entries that cover broad categories of conditions. When a Diabetic complication in the ICD-10 Index falls under the "NEC" category, the specific complications must be documented as linked to Diabetes by the terms "with," "due to" or "associated with." Coding professionals should not assume a causal relationship when the Diabetic complication is "NEC."

GRIEVANCE

As a Health Plan, we are required by CMS to fully investigate all grievances that are received by the Plan.

Grievances are defined by CMS in Chapter 13, Section 10.1 of the Medicare Managed Care Manual as "any complaint or dispute, other than the organization determination, expressing dissatisfaction with the manner in which a Medicare health plan or delegated entity provides health care services, regardless of whether any remedial action can be taken."

Additionally, in Section 20.3 of the same Chapter, CMS states that the Health Plan must have "prompt, appropriate action, including a full investigation of the grievance as expeditiously as the enrollee's case requires, based on the enrollee's health status, but no later than 30 calendar days from the date the oral or written request is received."

In some instances, a member may file a grievance against you as a provider regarding a treatment plan you have intended for the member. This could include indicating specific care needed or not needed, or medication that the member is requesting be provided.

As a Health Plan, we ask that you review each grievance and provide a statement to us by the date requested so that we can properly investigate a case. If in your medical judgement, a member does not need a requested medication or a specific course of treatment that would be a sufficient and appropriate response.

Together we continue to strive for excellent member service and understand that sometimes there are disagreements between providers and members over courses of treatment. As always, the Plan defers to the practicing provider for medical decision making. We thank you for your continued care to our members.

If you have any questions, please reach out to you Provider Relations Representative.

Stay tuned for future newsletters where you can find tips on how to prevent future grievances!

PCE: Pharmacotherapy Management of COPD Exacerbation

The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1–November 30 of the measurement year and who were dispensed appropriate medications

Two rates are reported:

1. Corticosteroid
The member is dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event.

2. Bronchodilator
The member is dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event.

These two rates should be completed every time a member has a qualifying COPD exacerbation event. A member can be part of the eligible population multiple times during the measurement year.

A comprehensive list of medications and NDC codes that qualify for this measure are available at www.ncqa.org

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

The IET HEDIS® Measure aims to quantify the percentage of adolescent and adult members who received treatment after a new episode of alcohol or other drug abuse or dependence (AOD).

Requirements

Progress notes documenting initiation of AOD treatment within 14 days of diagnosis, and two or more additional services within 34 days of the initiation visit.

The following time sensitive steps are required to meet measure compliance:

- Initiation of AOD treatment (a CMS Star Score measure) through an inpatient AOD admission, outpatient visit (including office visit), intensive outpatient encounter or partial hospitalization within 14 days of diagnosis.
- Engagement of AOD treatment for those who had two or more additional services with a diagnosis of AOD within 34 days of the initiation visit.

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 of our health care services!

Your Quality SCORES

Medical Record Standards

Our Plan's goal for medical record documentation compliance is to consistently excel across the ten (10) components noted below. 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

- The record is legible
- Past medical history
- History and physical
- Allergies and adverse reactions
- Problem list
- Medication list
- Working diagnoses and treatment plans
- Unresolved problems
- Documentation of clinical findings and evaluation
- 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.

The standards want to see the Plan meet Medical Record Review requirements as well as help 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:

www.youroptimumhealthcare.com/provider/education

www.freedomhealth.com/provider/tools_and_resources

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

2018 MRR Standard Component CY2017 Optimum Health	Frequency of Total Survey
Is the record legible?	98.56%
Is there an appropriate past medical history in the record?	98.08%
Is the history and physical documented?	98.56%
Are allergies and adverse reactions to medications prominently displayed?	96.88%
Is there a completed problem list?	98.32%
Is there a medication list?	97.60%
Is there a working diagnosis(es) and treatment plan(s)?	98.32%
Are unresolved problems documented?	90.38%
Is there documentation of clinical findings and evaluation?	68.03%
Is there documentation of preventive services and/or risk screening?	67.07%

Of those medical records reviewed, almost all met the goal of 90 percent or greater compliance. The two (2) individual components that scored lower than 90 percent was "Is there documentation of clinical finding and evaluation?" and "Is there documentation of preventive services and/ or risk screening?" in which the frequency of the total survey was 68.03 and 67.07 percent, respectively.

2018 MRR Standard Component CY2017 Freedom Health	Frequency of Total Survey
Is the record legible?	95.76%
Is there an appropriate past medical history in the record?	99.61%
Is the history and physical documented?	97.88%
Are allergies and adverse reactions to medications prominently displayed?	98.84%
Is there a completed problem list?	98.07%
Is there a medication list?	98.65%
Is there a working diagnosis(es) and treatment plan(s)?	99.81%
Are unresolved problems documented?	93.83%
Is there documentation of clinical findings and evaluation?	97.30%
Is there documentation of preventive services and/or risk screening?	95.83%

Of those medical records reviewed, all met the goal of 90 percent or greater compliance. The only two (2) individual components that scored lower (but still above goal) were "Are unresolved problems documented?" and "Is there documentation of preventive services and/or risk screening?" in which the frequency of the total survey were 93.83 and 95.83 percent, respectively

2018 MRR Standard Component CY2017 Medicaid Specialty	Frequency of Total Survey
Is the record legible?	100%
Is there an appropriate past medical history in the record?	100%
Is the history and physical documented?	100%
Are allergies and adverse reactions to medications prominently displayed?	87.5%
Is there a completed problem list?	95.8%
Is there a medication list?	95.8%
Is there a working diagnosis(es) and treatment plan(s)?	100%
Are unresolved problems documented?	100%
Is there documentation of clinical findings and evaluation?	95.8%
Is there documentation of preventive services and/or risk screening?	95.8%

Of those medical records reviewed, almost all met the goal of 90 percent or greater compliance. The only one (1) individual component that scored lower than 90 percent was "Are allergies & adverse reactions to medication prominently displayed?" in which the frequency of the total survey was 87.5 percent.

Quality Management

THE RESULTS ARE IN!

Our goal is to help our members improve their health by providing the best care and service options. In order to do this, we rely on our Quality Management (QM) program. The QM program monitors 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 Healthcare Effectiveness Data and Information Set. 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.

Our 2018 HEDIS® results show that our plans improved their performance and met quality goals in many HEDIS® measures. These areas include:

Follow-Up after Hospitalization for Mental Illness (FUH)

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported:

- The percentage of discharges for which the member received follow-up within 30 days after discharge.
- The percentage of discharges for which the member received follow-up within 7 days after discharge.

The following time sensitive steps are required to meet measure compliance:

30-Day Follow-Up: A follow-up visit with a mental health practitioner within 30 days after discharge.

7-Day Follow-Up: A follow-up visit with a mental health practitioner within 7 days after discharge.

Our 2018 HEDIS® results show that Optimum Healthcare improved its performance and met quality goals in many HEDIS® measures. These areas include:

- Antidepressant Med Mgmt: Acute and Continuation Phase Rx
- Breast Cancer Screening
- Colorectal Cancer Screenings
- Comprehensive Diabetes Care: Poor HbA1c Control >9 (inverted) and Good HbA1c Control <8
- Comprehensive Diabetes Care: Blood Pressure Controlled <140/90 mm Hg
- Comprehensive Diabetes Care: Eye Exams
- Use of High risk medications in the Elderly- one script (inverted)
- Medication Reconciliation Post-Discharge
- Osteoporosis Management in Women
- Pharmacotherapy Management of COPD: Bronchodilator
- RX in Rheumatoid Arthritis

Areas where we would like to improve our performance include:

- Adult Access to Preventive Services: 20-44 years
- Comprehensive Diabetes Care: HbA1c Testing
- Use of High risk medications in the Elderly- two scripts (inverted)
- Follow-Up Hospital Mental Illness
- Persistence of Beta Blocker Heart Attack
- Pharmacotherapy Management of COPD: Systemic corticosteroid
- Spirometry Testing for COPD

Our 2018 HEDIS® results show that Freedom Health improved its performance and met quality goals in many HEDIS® measures. These areas include:

- Antidepressant Medication Management
- Comprehensive Diabetes Care- Poor HbA1c Control >9 (inverted), Good HbA1c control <8 and HbA1c Testing
- Comprehensive Diabetes Care Blood Pressure Controlled <140/90 mm Hg
- Comprehensive Diabetes Care Eye Exams
- Medication Reconciliation Post-Discharge
- Osteoporosis Management in Women
- Rx in Rheumatoid Arthritis
- Areas where we would like to improve our rates include:
- Adult Access to Preventive Services
- Colorectal Cancer Screening
- Comprehensive Diabetes Care- Monitoring Diabetic Nephropathy
- Follow-up Hospital Mental Illness
- Pharmacotherapy Management of COPD
- Spirometry Testing for COPD

Our 2018 HEDIS® results show that Freedom 1st Specialty Medicaid was able to report its progress as it strives to address its quality goals in many HEDIS® measures. These areas include:

- Adult BMI Assessment
- AMM- Antidepressant Medication Management
- CAT Call Answer Timeliness
- CDC- Comprehensive Diabetes Care
- COA - Care for Older Adults
- Plan All Cause Readmission (PCR): 65+ Years

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

For more information on HEDIS® and Quality Measurement, go to: http://www.ncqa.org/HEDISQualityMeasurement.aspx

You can also call Member Services at 1-800-401-2740.

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Laboratory Reminder

Quest **(866) 697-8378**
www.QuestDiagnostics.Com

TIP: Lab and pathology tests for Freedom and Optimum HealthCare members performed at a participating facility can improve HEDIS® scores.

P.O. Box 151137
Tampa, FL 33684

Protections & Accountability

Our Member's Rights and Responsibilities

We have updated our list of Member Rights to 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 added 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 and Optimum HealthCare strongly endorses the rights of members as supported by State and Federal laws as well as other regulatory agencies. 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 and Optimum HealthCare 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