provider news

Dear Provider,

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) is planning to include two additional HEDIS® and Part D measures to the 2019 CMS Star Ratings Program (DOS 2017). Based on a document known as "The CMS Call Letter", released by CMS on April 3, 2017, the two measures to be included are:

- Statin Therapy for Patients with Cardiovascular Disease (Part C): The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one high or moderate-intensity statin medication during the measurement year.

- Statin Use in Persons with Diabetes (SUPD) (Part D): This measure is defined as the percentage of patients between 40 and 75 years old who received at least two diabetes medication fills and also received a statin medication fill during the measurement period.

These two measures are currently listed under what's known as the CMS's display page, which means that the entity has been collecting and analyzing data on these measures within the last few years. We anticipate that CMS will continue with their plan to include these measures as part of next year's submission of the 2019 star ratings data. For this reason we are taking a proactive approach to provide some general information about the intent of these measures.

Additionally, the Health Plan is already working diligently to include these measures in our 2018 release of the HEDIS® Portal (coming in April 2018).

We thank you for your continuous support and for being an essential part in providing the best quality of care to our members.

Sincerely,

Freedom Health and Optimum HealthCare

Printed and mailed on 12/19/2017

ENHANCING PATIENT-DOCTOR COMMUNICATION

Engage Your Patients with Your Notes

Do you have good communication with your patients?

Since one of the essential factors in achieving patient-centered care is good physician-patient communication, this is one element that should not be overlooked.

While it may not be customary, you can improve patient-physician communication by sharing your patient's medical notes with them. When patients are able to read their medical notes, it fosters patient engagement. Ultimately, when patients are more actively involved in their care, it enhances their care experiences, builds trust between the physician and patient, and improves their satisfaction.

Also, if a patient is able to read what is on the chart, he or she will have the opportunity to correct any mistakes or add other helpful details, thereby preventing medical errors. Notes-sharing also counts towards the Meaningful Use Stage 1 requirement of providing patients with an electronic copy of their health information, and the Stage 2 requirement of providing clinical summaries for patients for each office visit.

Keep in mind, though, while there are many platforms for sharing notes with patients, such as the successful OpenNotes project, physicians don't need to implement a formal electronic program to join this movement towards transparency and patient engagement. Rather, physicians can start engaging their patients today just by letting them look at their records during their regular appointments. It's a simple gesture with surprisingly beneficial results.

YOUR CREDENTIALS

How to Ensure a Smooth Re-Credentialing Process

Re-credentialing 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 expiration 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 timely submission!

Partner with Case and Disease Management Nurses

The Plan can collaborate with you to help provide each member the services they need to better manage their health or plan of care. Physicians and providers can refer a patient to one of our programs with just a phone call or written referral. Our overall goal is to support the member's success in implementing his or her plan of care. The referral form can be found on the Plan's website or in your Provider Manual.

Disease Case Managers can offer education and coaching programs for Members based on diagnoses such as Diabetes and Cardiovascular Disease. These programs are built around national evidence-based guidelines. The focus is on preventing complications and/or exacerbations, enhance self-management and reduce acute episodes.

Complex Case Managers can assist members with urgent or acute events and coordination of services. The goal is to enhance coping and problem solving capabilities, assist in appropriate self-direction, support proper and timely needed services and reduce readmissions.

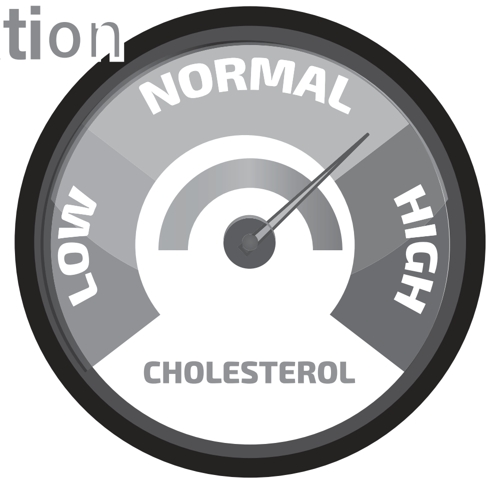
Social workers support is integrated into the Case and Disease Management programs to assess psychosocial issues and to identify community or other resources in which the member might benefit.

Members enrolled into one of our Case and Disease Management programs and their physicians receive ongoing support from nurses on staff. Members may choose not to participate in the program at any time and it does not affect their benefits. We encourage providers to support Member participation in these programs as a collaborative effort to maximize health. Provider communication efforts are via a care plan developed by the nurse and/or social worker highlighting mutually agreeable goals and interventions. Updates to the care plan are provided as well when initiatives change.

Call us toll-free at 1-888-211-9913 from 8:00 a.m. to 4:30 p.m. Monday through Friday.

To access the referral form on the internet visit the Plan website and follow this path: Providers -> Tools and Resources -> Case/Disease Management Referral Form

Encouraging Active Participation in Cholesterol Management



The Plan's Disease Case Managers often work with members (who suffer from cardiovascular issues. One topic frequently (discussed with these members is cholesterol's influence on CV (risk. In the last four years of the Plan's CMS mandated Chronic (Care Improvement Program focused on cardiovascular disease (and reducing its risk, members have provided the Disease (Management nurses with anecdotal feedback related to their (lack of engagement for cholesterol management. (

This includes:

- Not knowing their cholesterol numbers or understanding why they are important.
- A lack of interest because their physicians have not mentioned the need for cholesterol management to them.
- Due to no symptoms of high cholesterol, members were unconvinced that lifestyle changes were indicated.
- That their doctor was already treating them for high cholesterol so they don't need any information from the Plan.

However, many understand don't the different types of cholesterol, especially which is "good" and which is "bad". In addition to sharing these values with your patients, it is important to differentiate between them, explain what exactly their levels mean in regards to their health, and provide helpful tips for how they can manage their cholesterol with self-management techniques. It is important that members understand their plan of care so that they can play an active role in managing their health.

Disease Management staff can be of assistance in coaching these and other individuals with chronic conditions such as diabetes and COPD. Call the Case/Disease Management Department with any questions or to refer a member to the program. The nurse can be reached at 1-888-211-9913 or through a referral form located on the Plan website and in your Provider Manual.

YOUR ROLE -
Depression Screening and Follow-Up

The National Committee for Quality Assurance (NCQA) has included depression screening as one of its seven new quality measures for HEDIS year 2018. The new measure, officially titled 'Depression Screening and Follow-Up for Adolescents and Adults', assesses the percentage of health plan members 12 years and older who were screened for clinical depression and, if screened positive, received follow-up care. The intent is to address the needs of patients throughout the spectrum of care for depression: screening, ongoing monitoring and response to treatment.

The Plan already places an emphasis on depression screening and treatment through one of its CMS-mandated Quality Improvement Projects (QIP), which was started in January 2016 and continues through December 2018. Members noting symptoms of depression on their returned Health Assessment Tool trigger in for additional screening by a Plan social worker. PCPs are copied on all information provided to the member related to depression and behavioral health services that are available. The social workers may suggest that you additionally screen for services if the member voices an interest in his/her PCP managing the concerns.

If a member is determined to be depressed, consider referring for additional behavioral health services. The Plan's behavioral health services provider, Beacon Health Options, can be accessed by calling 1-800-221-5487 (option 2 for providers). Social services staff at the plan can also assist in linking members to services. Please use the Case and Disease Management Referral Form found online or in your Provider Manual, or call 1-888-211-9913 to reach the Plan Social Workers.

Note: *In 2018, this QIP Depression Project will transition into the Chronic Care Improvement Program (CCIP) as directed by CMS but will still continue in its current format. Partnerships with providers will continue as an essential component to ensure that members are screened for depression and subsequently receive proper treatment and ongoing monitoring, if indicated.*

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provider news
Winter 2017

P.O. Box 151137, Tampa, FL 33684

A Letter from Nancy Gareau

2017 was an excellent year for Freedom Health and Optimum HealthCare. Heading into 2018, Freedom Health received a 4 Star rating from CMS and Optimum HealthCare has achieved the distinction of being awarded 5 Stars. Optimum HealthCare is the only Medicare Advantage Plan in Florida to accomplish this two years in a row. We have also enjoyed our status of being one of the largest Medicare Advantage plans in the State of Florida and maintaining our NCQA Accreditation.

As we close out a very exciting year for our health plans and look forward to 2018, I would like to take a moment to thank you for your significant contribution to our success. Without your participation, we could not achieve the quality of care we strive to deliver to the communities we serve.

The entire team at Freedom Health and Optimum HealthCare wish you and your families a very Happy Holiday season and all the very best in 2018!

Nancy Gareau
V.P. Network Operations/Business

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