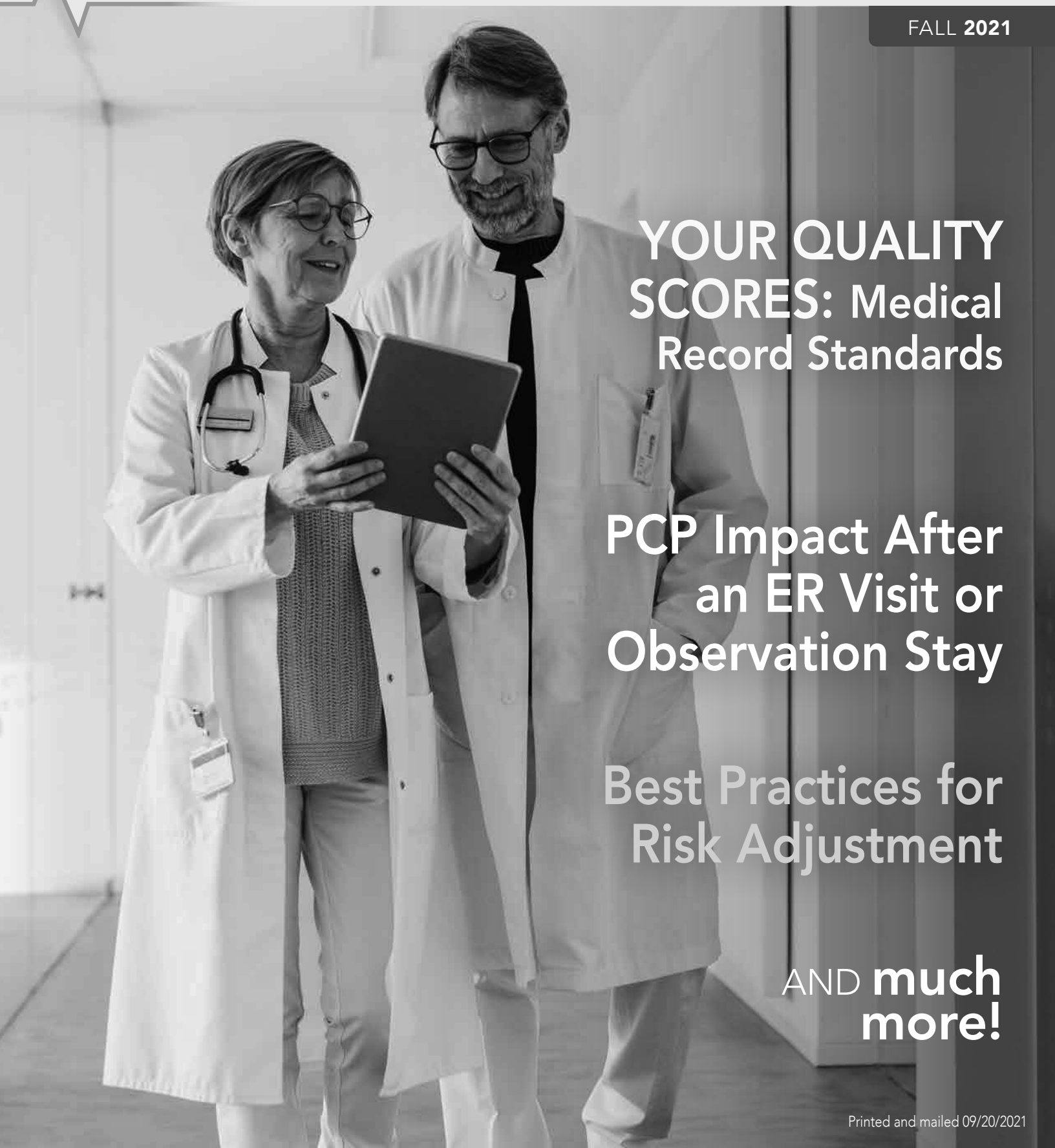
providerNEWS

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

FALL **2021**



YOUR QUALITY SCORES: Medical Record Standards

PCP Impact After an ER Visit or Observation Stay

Best Practices for Risk Adjustment

AND **much more!**

Printed and mailed 09/20/2021

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

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.

2021 MRR Standard Component Freedom Health	Frequency of Total Survey
Is the record legible?	**100.0%**
Is there an appropriate past medical history in the record?	**94.5%**
Is the history & physical documented?	**97.3%**
Are allergies & adverse reactions to medications prominently displayed?	**95.3%**
Is there a completed problem list?	**31.6%**
Is there a medication list?	**97.3%**
Is there a working diagnosis(es) and treatment plan(s)?	**96.9%**
Are unresolved problems documented?	**45.9%**
Is there documentation of clinical findings and evaluation?	**97.7%**
Is there documentation of preventive services and/or risk screening?	**92.8%**

Mean overall component** ***84.9%

There were 166 providers whose records were reviewed which resulted in 3099 medical records, in which the overall mean score was 84.9 percent of the total of the components, which is -5.1 percent below the internal benchmark. There were two (2) individual components that did not meet the established 90% internal Health Plan benchmark, "Is there a completed problem list?", and "Are unresolved problems documented?" in which the frequency of the total surveys were 31.6 percent, and 45.9 percent respectively. These components scored low and are in need of improvement. Our goal is to educate our healthcare providers on meeting the performance goals for the 2021 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 previous visits 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 website:

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

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).

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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.

2021 MRR Standard Component Optimum HealthCare	Frequency of Total Survey
Is the record legible?	**100.0%**
Is there an appropriate past medical history in the record?	**81.5%**
Is the history & physical documented?	**95.5%**
Are allergies & adverse reactions to medications prominently displayed?	**90.6%**
Is there a completed problem list?	**12.3%**
Is there a medication list?	**94.6%**
Is there a working diagnosis(es) and treatment plan(s)?	**98.5%**
Are unresolved problems documented?	**17.6%**
Is there documentation of clinical findings and evaluation?	**94.2%**
Is there documentation of preventive services and/or risk screening?	**96.0%**

***Mean overall component 78.1%**

There were 129 providers whose records were reviewed which resulted in 2435 medical records, in which the overall mean score was 78.1 percent of the total of the components, which is -11.9 percent below the internal benchmark. There were three (3) individual components that did not meet the established 90% internal Health Plan benchmark, "Is there a completed problem list?", "Are unresolved problems documented?" and "Is there an appropriate past medical history in the record" in which the frequency of the total surveys were 12.3 percent, 17.6 percent, and 81.5 percent respectively. These components that scored low are in need of improvement. Our goal is to educate our healthcare providers on meeting the performance goals for the 2021 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 previous visits 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.

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Following up:

PCP Impact After an ER Visit or Observation Stay

The Plan's Model of Care 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 Provider (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. 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, PCPs 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.

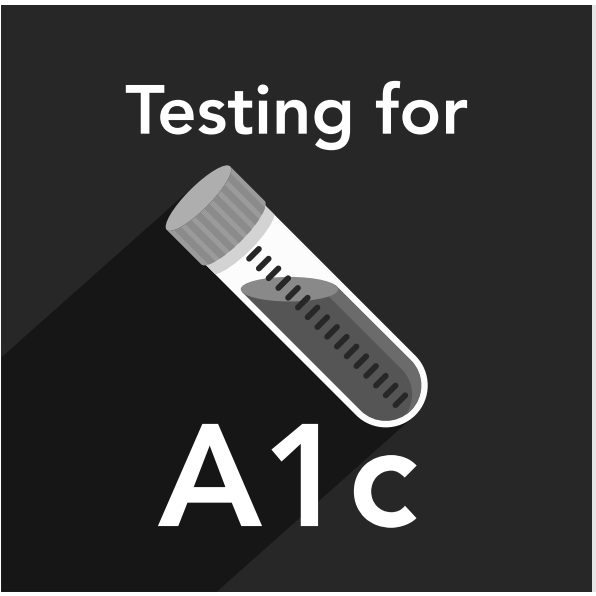
During this follow-up visit, the PCP can review with the patient any treatment plan or medication changes, make referrals to specialists and address barriers that can interfere with the healing process. This is a collaborative review and the patient should be encouraged to ask questions. ***Observation 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 30 days or sooner, 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 will ensure that the results get communicated without any additional effort.

CREDENTIALING CORNER

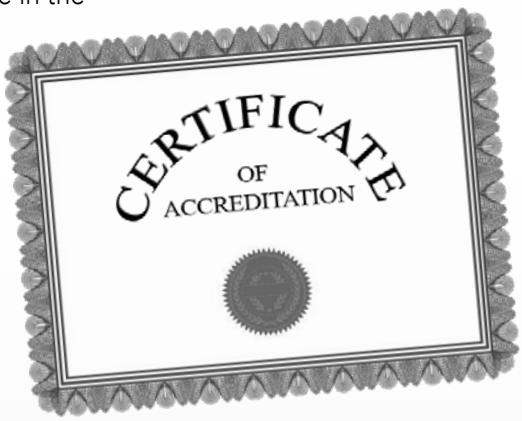
The plan sends notification of re-credentialing by mail four months in advance of a providers scheduled re-credentialing due date.

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)**
- **DEA Certificate**
- **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 along with the Plan application which needs to be completed and returned; and a list of documents needed for re-credentialing as well as the deadline for the submission.

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

Thank you for your timely submission!

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. 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!

Best Practices for RISK ADJUSTMENT

Successful coding for Risk Adjustment continues to be heavily driven by specificity in documentation translating into accurate code assignment. The requirement for greater specificity has only become more imperative within the current climate of increased telehealth visits. To qualify as a face-to-face visit for risk adjustment, telehealth progress notes must document the use of an interactive, real-time **audio and video** telecommunications system to complete the visit. Providers should use CPT Telehealth modifier "95" to indicate telehealth visits.

To adhere to Risk Adjustment guidelines, the progress note must be complete, legible, support all active diagnoses and have the ability to stand alone for each date of service. All diagnoses that coexist at the time of the encounter/visit, and require or affect patient care, treatment, or management should be documented and coded. Documentation should include the highest level of specificity along with a status and plan of care to properly support each diagnosis reported. Often, a greater level of specificity can be the difference that supports the associated HCC.

Although ICD-10 coding guidelines do allow the automatic linkage between conditions in some circumstances, these rules do not apply to every condition, so documentation should specifically state any causal relationship to ensure proper coding. Use caution when documenting and coding acute conditions in the outpatient setting, such as an acute CVA, which indicates the acute stroke is happening within the provider office. Rather, history of the stroke is likely appropriate documentation and coding, as well as any active residual deficits, as applicable. Ensure the appropriate use of "history of" codes for acute conditions that are no longer active and/or are documented as resolved.

As a reminder, the upcoming new 2022 ICD-10-CM Code set and Guidelines will be effective October 1st, 2021. Additionally, Physician-to-Physician MRA Education is being provided. Requests can be emailed to riskadjustment@freedomh.com.

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 and Optimum Healthcare 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 and Optimum 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 at Freedom Healthcare 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 **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.

Our 2020 HEDIS® 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
- Controlling High Blood Pressure
- Colorectal Cancer Screenings
- Comprehensive Diabetes Care: HbA1c Control < 8.0%
- Comprehensive Diabetes Care: Blood Pressure Controlled <140/90 mm Hg
- Comprehensive Diabetes Care: Eye Exams
- Colorectal Cancer Screening
- Transition of Care: Medication Reconciliation Post- Discharge

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

- Comprehensive Diabetes Care: Poor HbA1c Control > 9.0%
- Follow-Up Hospital Mental Illness
- Osteoporosis Management in Women
- Pharmacotherapy Management of COPD: Systemic Corticosteroid
- Pharmacotherapy Management of COPD: Bronchodilator

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.

CDC – Comprehensive Diabetes Care: Poor HbA1c Control > 9.0%
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had Poor HbA1c Control > 9.0%. An HbA1c test is performed during the measurement year.

Requirements:

- The member's most recent HbA1c level is greater than 9.0% or is missing a result, or if an HbA1c test was not done during the measurement year.
  - Documented through laboratory data or medical record
  - A lower rate indicates better performance for this measure as it is an inverse measure (i.e., low rates of poor control indicate better care).

Providers are required when documenting in the medical record a note to indicate the HbA1c performed test date and the distinct numeric result. The result for the most recent HbA1c level during the measurement year should be less than 9.0%.

"The Results are in!"

FUH – Follow-Up after Hospitalization for Mental Illness
The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider.

Requirements:
1. Outpatient visit ***with*** a mental health provider
2 .An intensive outpatient encounter or partial hospitalization
3. A community mental health center visit
4. Electroconvulsive therapy
5. Observation visit
6. A telehealth visit ***with*** a mental health provider
7. Transitional care management services ***with*** a mental health provider
8. A behavioral healthcare setting visit
9. A telephone visit ***with*** a mental health provider

Two rates are reported:
- The percentage of discharges for which the member received follow-up within 30 days after discharge.
  - A follow-up visit with a mental health practitioner within 30 days after discharge.
- The percentage of discharges for which the member received follow-up within 7 days after discharge.
  - A follow-up visit with a mental health practitioner within 7 days after discharge.

OMW – Osteoporosis Management in Women Who Had a Fracture
The percentage of women 67–85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.

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.
2. Osteoporosis Medication Therapy in the six months after the fracture.

Many patients miss basic screenings and tests not knowing they are free of cost and can have assistance scheduling them. Let your patients know about the many health service options available to them through our Plan's benefits and services. It may be as simple as instructing them to call our Member Services team and providing the patient with a referral to the appropriate provider.

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 prescription for systemic corticosteroid (Systemic Corticosteroid Medications List) within 14 days of the event. Count systemic corticosteroids that are active on the relevant date.

2. **Bronchodilator**

   The member is dispensed prescription for a bronchodilator within 30 days of the event. Count bronchodilators that are active on the relevant date.

Note: *The eligible population for this measure is based on acute inpatient discharges and ED visits, not on members. It is possible for the denominator to include multiple events for the same individual.*

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

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!

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

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

Quality Management: "The Results are in!"

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- Antidepressant Medication Management: Continuation Phase Rx
- Controlling High Blood Pressure
- Comprehensive Diabetes Care: Blood Pressure Controlled <140/90 mm Hg
- Comprehensive Diabetes Care: Nephropathy
- Transition of Care: Medication Reconciliation Post- Discharge
- Pharmacotherapy Management of COPD: Bronchodilator

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

- Colorectal Cancer Screening
- Follow-Up Hospital Mental Illness
- Osteoporosis Management in Women
- Persistent of Beta-Blocker Treatment After a Heart Attack

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You can also call Member Services at 1-866-245-5360.

COL - Colorectal Cancer Screening
The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.

Requirements:
One or more screenings for colorectal cancer. Any of the following meet criteria:
1. Fecal occult blood test during the measurement year.
2. Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year.
3. Colonoscopy during the measurement year or the nine years prior to the measurement year.
4. CT colonography during the measurement year or the four years prior to the measurement year.
5. FIT-DNA test during the measurement year or the two years prior to the measurement year.

FUH – Follow-Up after Hospitalization for Mental Illness
The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider.

Requirements:
1. Outpatient visit ***with*** a mental health provider
2. An intensive outpatient encounter or partial hospitalization
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4. Electroconvulsive therapy
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PBH – Persistence of Beta-Blocker Treatment After a Heart Attack
The percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge. Members are to be 135 days of treatment with beta-blockers (Beta-Blocker Medications List) during the 180-day measurement interval. This allows gaps in medication treatment of up to a total of 45 days during the 180-day measurement interval. Beta-blocker medications include the noncardioselective beta-blockers, cardioselective beta-blockers and antihypertensive combinations.

To identify an acute inpatient discharge:
1. Identify all acute and nonacute inpatient stays
2. Exclude nonacute inpatient stays
3. Identify the discharge date for the stay

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

PROVIDER RELATIONS DEPARTMENT 2021

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FREEDOM HEALTH

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FALL 2021

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