Provider Newsletter

Hawai'i | 2018 | Issue I

Ombudsman Program and Providers

The State of Hawaii has expanded the Ombudsman Program to also incorporate provider inquiries as well. It is an independent reviewer, to look into concerns against the QUEST Integration Health Plans. They can help:

- Make sure you have access to care for your members
- Promoting quality of care

It is available to all providers. You can learn more by contacting the Hilopa`a Family to Family health Center Information Center. You can visit their website at **www.hilopaa.org**. You can also call, fax or email them:

Island	
Oahu	1-808-791-3467
Hawai`i	1-808-333-3053
Maui and Lana`i	1-808-270-1536
Moloka`i	1-808-660-0063
Kaua`i	1-808-240-0485

Email: **ombudsman@hilopaa.org**

Fax: **1-808-531-3595**

In This Issue

Join the Conversation on Social Media

Join our digital and social communities for up-to-date information on how we're working with you and others to help our members live better, healthier lives.

BLOG

We're in this together: *Quality Health Care*

'OHANA Health Plan

Availability of Criteria

The review criteria and guidelines are available to the providers upon request. Providers may request a copy of the criteria by calling our Customer Service department at the number listed at the end of this newsletter.

Please remember that all Clinical Coverage Guidelines, detailing medical necessity criteria for several medical procedures, devices and tests, are available via the provider resources link at: **www.ohanahealthplan.com.**

Updating Provider Directory Information

We rely on our provider network to advise us of demographic changes so we can keep our information current.

To ensure our members and Service Coordination staff have up-to-date provider information, please give us advance notice of changes you make to your office phone number, office address or panel status (open/closed). Thirty-day advance notice is recommended.

New Phone Number, Office Address or Change in Panel Status:

Send a letter on your letterhead with the updated information. Please include contact information if we need to follow up with you.

Please send the letter by any of these methods:

- Fax: **1-866-788-9910**
- Mail: **'Ohana Health Plan**
  Attention: Provider Operations
  949 Kamokila Blvd., Suite 350
  Kapolei, HI 96707

Thank you for helping us maintain up-to-date directory information for your practice.

Quality Stars

'Ohana values everything you do to deliver quality care to our members – your patients – to make sure they have a positive healthcare experience. That's why we're asking you to join us in giving your patients optimal care to help improve quality scores!

'Ohana's Quality Improvement Program monitors multiple measures that reflect your patients' experiences and health. The following measures are used to reflect the quality of patient care:

- CAHPS® Survey
- HEDIS® Measures
- HOS Survey
- Pharmacy Measures

The Stars Score is a summary of many of these measures and may affect Pay-for-Performance (P4P) provider incentives. You can help us improve scores by taking the actions suggested below. Please contact your Provider Relations representative if you have questions or need assistance. We're here to help you.

Adult BMI – Help your patients live healthier by discussing their weight, diet and physical activity levels during preventive care visits.

Be sure to record calculated body mass index (BMI) in all patient medical records as well as height and weight. Explain BMI to your patients and help them reach a healthy BMI.

Care for Older Adults: Medication Review – Use these strategies to make sure your patients' medications are current, non-conflicting and being taken appropriately:

- Encourage your patients to bring in all their medications and supplements for the patient's annual wellness visits. Review what they're taking and why.
- When explaining medication instructions, ask each patient to repeat the instructions back to you to ensure total comprehension
- Eliminate unnecessary or outdated medications. Simplify medications when possible.

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Care for Older Adults: Functional Status Assessment – Bring your patients in for a preventive care visit and to complete a functional status assessment.

Adults ages 66 and older can struggle to do basic tasks as they age. As a healthcare provider, you should understand what your patients are going through and help them understand the difficulties they may face as they age. See how well they can do activities of daily living, such as dressing, eating and bathing.

Care for Older Adults: Pain Assessment – During your regular visits with older patients, conduct a pain screening. Help them develop a pain management plan at least once during the year.

High-Risk Medication – Review everything your patients are taking and consider alternatives to high-risk drugs. Consult the 'Ohana formulary for a comprehensive list of high-risk drugs.

MTM Program Completion Rate for CMR – Some plan members are a Medication Therapy Management (MTM) program to help them manage their prescription drugs. Advise patients to participate in an MTM program when offered (based on eligibility). Members are selected for this CMR program based on eligibility.

Statin Therapy for People with Cardiovascular Disease – Prescribe statin drugs for patients with cardiovascular disease. A 90-day supply might improve adherence.

Select lowest-tier medications from the formulary for your patient. Use our formulary search tool at **www.ohanahealthplan.com** to identify the best medication.

Prescribe the medication electronically to the patient's pharmacy of choice.

Make it easier for the patient to adhere to treatment by prescribing a 90-day supply, mail order or auto-refills, especially for patients stable on therapy.

Controlling Blood Pressure – Schedule quarterly visits with your patients with hypertension to help them control their blood pressure.

Encourage patients to make healthy lifestyle changes to help control their blood pressure

- Achieve and maintain a healthy body weight
- Participate in some form of physical activity each day
- Reduce salt intake to 1500 mg a day. Beware of fast foods and prepackaged, processed foods, which are often high in salt
- If blood pressure remains out of control, consider medication therapy

Medication Adherence for Hypertension – Please remind your patients about medication adherence. Help them understand the importance of each medication and why they take it.

These points can improve adherence:

- Talk with your patients about adherence and identify their barriers
- Reduce pill burden when appropriate and help your patient set reminders and routines
- Make sure patients understand the instructions for taking the medication
- If cost is an issue, consider lower-tier medications in the same drug class
- Write 90-day supplies for patients who are stable at their current dose

Medication Adherence for Cholesterol (Statins) – Utilize the RxEffect portal to easily identify patients with high cholesterol who require medication adherence support.

Consider statin drug therapy for high-cholesterol patients. Statin drugs help lower cholesterol and reduce the risk of cardiac events and stroke.

These drugs will help your patients only if taken correctly.

Getting Needed Care

Access to medical care, including primary care, specialist appointments and appointment access, are key elements of quality care. Each year, CAHPS® surveys patients and asks questions like:

- **In the last 6 months,** how often was it easy to get appointments with specialists?
- **In the last 6 months,** how often was it easy to get the care, tests, or treatment you needed through your health plan?
- **In the last 6 months,** when you needed care right away, how often did you get care as soon as you thought you needed?
- **In the last 6 months,** not counting the times when you needed care right away, how often did you get an appointment for your healthcare at a doctor's office or clinic as soon as you thought you needed?
- **In the last 6 months,** how often did you see the doctor you were scheduled to see within 15 minutes of your appointment time?

To ensure your patients are satisfied with their ease of access:

- See members within access and availability standards
- Schedule appointments in a reasonable window for each request
- Follow up with members after referral to specialists to ensure care is coordinated
- Provide all information for specialists, tests and procedure authorizations and follow up as necessary
- Reduce time in the waiting room to no more than 15 minutes from appointment time

Care Coordination

These are also helpful tips to provide the needed care to your patients:

- Review medications with your patients
- Offer to schedule specialist and lab appointments while your patients are in the office
- Remind your patients about annual flu shots and other immunizations
- Make sure your patients know you also are working with specialists on their care. Ensure you receive notes from specialists about the patient's care and reach out to specialists if you have not gotten consultation notes. Tell your patient the results of all test and procedures. Share decision making with patients to help them manage care. And please follow up on all authorizations requested for your patient
- Call or contact your patients to remind them when it's time for preventive care services such as annual wellness exams, recommended cancer screenings and follow-up care for ongoing conditions such as hypertension and diabetes

Provider Formulary Updates

Medicaid:

There have been updates to the QUEST Integration Preferred Drug List (PDL). Visit **www.ohanahealthplan.com/provider/pharmacy** to view the current PDL and pharmacy updates.

You can also refer to the Provider Manual available at **www.ohanahealthplan.com/provider/medicaid/resources** to view more information on 'Ohana's pharmacy Utilization Management (UM) policies/procedures.

Community Care Services:

Visit **www.ohanaccs.com/provider/pharmacy** to view the current PDL and pharmacy updates. You can also refer to the *Provider Manual* available at **www.ohanaccs.com/provider** to view more information on 'Ohana's pharmacy UM policies and procedures.

Medicare:

Updates have been made to the Medicare Formulary. Find the most up-to-date complete formulary at **www.ohanahealthplan.com/provider**, and click *Pharmacy* under Medicare icon.

You can also refer to the *Provider Manual* available at **www. ohanahealthplan.com/provider**, and click *Overview* under Medicare icon. You can also view more information on 'Ohana's pharmacy UM policies and procedures.

Updated Clinical Practice Guidelines

Clinical Practice Guidelines (CPGs) are best practice recommendations based on available clinical outcomes and scientific evidence. They also reference evidence-based standards to ensure that the guidelines contain the highest level of research and scientific content. CPGs are also used to guide efforts to improve the quality of care in our membership. CPGs on the following topics have been updated and published to the Provider website:

- Acute and Chronic Kidney Disease: HS-1006
- ADHD: HS-1020
- Adolescent Preventive Health: HS-1051*
- Adult Preventive Health: HS-1018
- Anxiety Disorders: HS-1057*
- Asthma: HS-1001
- Behavioral Health Conditions and Substance Use in High Risk Pregnancy: HS-1040
- Behavioral Health Screening in Primary Care Settings: HS-1036
- Bipolar Disorder: HS-1017
- Cancer: HS-1034
- Cardiovascular Disease: HS-1002
- Child and Adolescent Behavioral Health: HS-1049*
- Cholesterol Management: HS-1005
- Congestive Heart Failure: HS-1003
- COPD: HS-1007
- Dental and Oral Health: HS-1065
- Depressive Disorders in Children, Adolescents and Adults: HS-1022
- Eating Disorders: HS-1046
- Fall Risk Assessment: HS-1033
- Frailty and Special Populations: HS-1052*
- Hepatitis: HS-1050 NEW
- HIV Screening & Antiretroviral Treatment: HS-1024
- Hypertension: HS-1010
- Managing Infections: HS-1037
- Neonatal and Infant Health: HS-1072*
- Neurodegenerative Disease: HS-1032 (previously Alzheimer's Disease)
- Obesity in Children and Adults: HS-1014
- Older Adult Preventive Health: HS-1063
- Osteoporosis: HS-1015
- Palliative Care: HS-1043
- Pediatric Preventive Health: HS-1019
- Persons with Serious Mental Illness and Medical Comorbidities: HS-1044
- Pneumonia: HS-1062
- Post-Traumatic Stress Disorder: HS-1048*
- Rheumatoid Arthritis: HS-1025
- Sickle Cell Anemia: HS-1038
- Schizophrenia: HS-1026
- Substance Use Disorders: HS-1031
- Suicidal Behavior: HS-1027
- Traumatic Brain Injury (TBI): HS-1065*

*** New**

Clinical Policy Guiding Documents

- CPG Hierarchy
- Health Equity, Literacy, and Cultural Competency*

*** New**

The following CPGs have been retired and have been removed from the website:

- Acute Kidney Injury: HS-1069
- Antipsychotic Drug Use in Children: HS-1045
- Behavioral Health and Sexual Offenders in Adults: HS-1039
- Imaging for Low Back Pain: HS-1012
- Lead Exposure: HS-1011
- Motivational Interviewing & Health Behavior Change: HS-1042
- Pharyngitis: HS-1021
- Psychotropic Use in Children : HS 1047
- Screening, Brief Intervention, & Referral to Treatment (SBIRT): HS-1056
- Transitions of Care: HS-1054
- Major Depressive Disorder in Adults: HS-1008
- Substance Use Disorders in High Risk Pregnancy: HS-1041*

To access other CPGs related to Behavioral, Chronic, and Preventive Health, visit **www.wellcare.com/Hawaii/Providers**.

Cancer Screening Saves Lives

Screening for colorectal cancer can help find cancer early, when it might be easier to treat. Physicians and other clinicians are well aware of the benefits of screening, but many patients are not up to date with screening.

Colorectal cancer is the second-leading cause of cancer deaths in the United States among men and women combined, but screening can help prevent colorectal cancer. About 135,000 new cases and more than 50,000 deaths were estimated in 2017.

Talking with a physician or other clinician is one of the biggest factors that influences whether a patient is screened for colorectal cancer. You can help more patients get screened by discussing screening options and the risks and benefits of those options with your patients. Patients are often aware of colonoscopy as an option for screening, but they might not know as much about stool testing.

- Studies have shown that annual high-quality stool tests, such as high sensitivity GUIAC and fecal immunochemical tests can lower the risk of developing and dying from CRC.
- Use stool tests only for average risk patients (no personal or family history of CRC, adenomas or genetic syndromes)
- Make sure patients perform annual stool testing if they selecting gFOBT or FIT tests and that they understand the instructions in the kit they are using
- Stool samples should never be used for CRC screening if they are obtained by digital rectal exam because they have a low sensitivity for cancer
- All patients who have a positive stool test must have a follow-up colonoscopy
- WellCare covers one screening test a year
- ‘Ohana has provided over 70,000 FIT kits to patients for easy screening

Review ACS CRC Screening guidelines to determine your patient’s risk category and screening recommendations.

Review the risks and benefits of all CRC screening tests with your patients. If they are at average risk, discuss high-quality stool-based testing and offer them the choice that is right for them. Make sure they understand the risks and benefits of high-quality stool-based testing.

Thank you for working with ‘Ohana to make sure our members — your patients — get the care they need.

Access to Staff

If you have questions about the utilization management program, please call Customer Service at **1-888-846-4262**. TTY/TDD users call **711**. Language services are offered.

You may also review the Utilization Management Program section of your Provider Manual. You may call to ask for materials in a different format. This includes other languages, large print and audio tapes. There is no charge for this.

1139 DHS Contract Process Overview

Have you heard facilities/providers/prescribers/pharmacies/DME providers talking about the 1139 DHS Contract Process? If not, here is a brief overview of what is happening:

What is the 1139 process?

- Effective Jan. 1, 2018 all providers that service Hawaii Medicaid members need to be contracted with the State of Hawaii. To contract with the State, the provider must fill out the 1139 form and return it to the State as soon as possible. This was required to be completed by Dec. 31, 2017, and still needs to be completed if it hasn't been filled out yet.

How many providers are contracted with the State of Hawaii?

- According to the most recent meeting only a few hundred providers have actually gone through the entire process from start to finish so there is much more work to be done

What happens if a provider is not contracted on January 1st

- According to the Federal regulations, the provider may not be able to service Medicaid members after this date unless contracted with the State.

What is 'Ohana and the State doing about it?

- Our Senior Leadership has been working with the State as well as the other Health Plans to make sure our messaging is the same
- The State is working with CMS to ensure all Providers are able to continue to serve Medicaid members, and that these members have access to services even after Jan. 1, 2018
- The State has sent a letter with the 1139 form to all providers

What can you do to help?

- Please encourage the provider to complete the process as soon as possible
- The 1139 form is located on the med-quest.us site if the provider needs another copy
- **http://www.med-quest.us/providers/ProvidersApp.html**
- Please direct them back to the State if they have any questions on finding the form or how to complete the form. If they have any questions, they should contact Department of Human Services, Med-QUEST Division via email at **hcsbinquiries@dhs.hawaii.gov** or telephone at **808-692-8099**.

Register Now!
'Ohana's New Provider Portal

You wanted a simpler, more efficient way to interact with us. We delivered.

The new portal is now live and packed with features to help you care for your patients – our members – to ensure they have a positive healthcare experience. Login or register now at **https://provider.wellcare.com**

The portal features improved claims and authorizations tools, a more holistic view of member information and some new tools that offer more convenient ways for you to connect with us.

Features such as the My Practice area allow provider administrators to manage their users, permissions and access requests. The Visit Checklist feature will enable you to quickly create, print and submit an appointment agenda.

For information on how to use the new Provider Portal and more, watch this video: **www.wellcare.com/providers/video**
Or access video training here: **https://www.wellcare.com/Providers/New-Provider-Portal-Overview-Training**

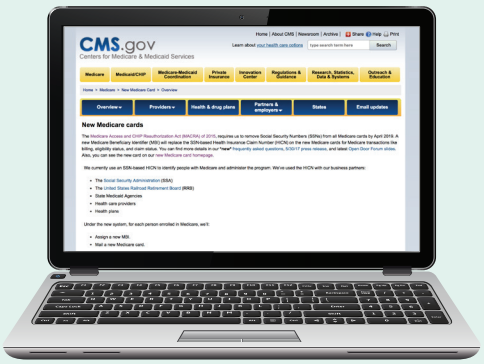
If you have questions, please contact your local Provider Relations representative, or call Provider Services.

Formulary News: Statin Use in Diabetes

The use of statin medications in patients ages 40–75 with diabetes and LDL from 70–189 mcg/dL is recommended by the American College of Cardiology (ACC) and the American Heart Association (AHA). This recommendation is included in the most recent Adult Treatment Panel (ATP) IV guidelines.

For your patients diagnosed with diabetes, consider starting the patient on a moderate- or high-intensity statin medication, depending on the patient's risk factors. For your convenience, we have listed the moderate and high-intensity statin medications that are preferred on 'Ohana's formulary:

Preferred Formulary Statins
High Intensity
Atorvastatin 40, 80 mg
Rosuvastatin 20, 40 mg
Moderate Intensity
Atorvastatin 10, 20 mg
Rosuvastatin 5, 10 mg
Simvastatin 20, 40 mg
Pravastatin 40, 80 mg



Medicare Access & CHIP Reauthorization Act of 2015.

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, requires the removal of Social Security Numbers (SSNs) from all Medicare cards by April 2019. A new Medicare Beneficiary Identifier (MBI) will replace the SSN-based Health Insurance Claim Number (HICN) on the new Medicare cards for Medicare transactions such as billing, eligibility status and claim status.

This mandate is required by CMS. Providers should review their practice management systems and business processes to determine what changes you need to use the new Medicare Beneficiary Identifier (MBI). You'll need to change and test your system/process by April 2018, before CMS mails out new Medicare cards.

If you use vendors to bill Medicare, you should contact them to find out about their MBI practice management system changes.

For more information and requirements, please click on this link: **www.cms.gov/Medicare/New-Medicare-Card/index.html**

PCP Request to Transfer a Member

'Ohana Health Plan, Inc. would like to ensure our Providers are aware of the appropriate process for requesting Members to be removed from their patient panel. Primary Care Providers (PCPs) may request that a Member be removed from their patient panel if the provider feels that the Member is non-compliant with the provider's treatment plan or plan of care, if there is evidence of abusive or inappropriate behavior, or if the provider is unable to adequately address the Member's needs. 'Ohana has established a uniform policy to ensure the proper evaluation and processing of provider requests to transfer/reassign Members from their patient panel.

It is the policy of 'Ohana to comply with specific State and/or Federal contractual requirements that allow the PCPs to request the transfer of a Member. The Provider shall continue to provide medical care for the 'Ohana Member until such time that written notification is received from 'Ohana stating that the Member has been transferred from the Provider's practice.

The full detailed outline of this process can be located in the Provider Manual under the 'Termination of a Member' section. Primary care providers can now request to transfer a member from their patient panel based on one of the above-mentioned qualifying reasons via the New Provider Portal. This new online submission option replaces the previous fax form process.

Providers can log onto the secured provider portal via **https://provider.wellcare.com**. Once on the home screen, providers will select "My Patients" at the top; choose the member; then select the Action: "Request Member Transfer." Supporting documentation such as office notes and/or clinicals are required for completion of each submission. Requests to transfer a member are reviewed for accuracy and completion. Requesting providers will receive confirmation from Customer Service once the transfer is completed.

Admission Notifications and Prior Authorizations

THIS IS A REMINDER OF CURRENT POLICY

Notification when an 'Ohana member is admitted to a facility:

As a reminder, 'Ohana requires notification by the next business day when a member is admitted to a facility. This includes all admissions and/or observation stays. Notification is necessary for 'Ohana to obtain clinical information to perform case management and ensure coordination of services. Failure to notify 'Ohana of admissions or observation stays may result in denial of the claim.

Prior authorization for outpatient services:

'Ohana has enhanced and standardized the provider portal authorization look-up tool with respect to place of service and clinical appropriateness. To reflect industry best practices and reduce the administrative burden on providers, the number of procedures requiring prior authorization has been reduced. Please remember to consult the authorization look-up tool on the provider portal and obtain appropriate prior authorization. Failure to obtain prior authorization where required may result in denial of the claim.

We value your partnership and work to ensure that every 'Ohana member receives quality healthcare.

EFT through PaySpan

Five reasons to sign up today for EFT:

- No interrupting your busy schedule to deposit a check.
- No waiting in line at the bank.
- No lost, stolen, or stale-dated checks.
- **You** control your banking information.
- Immediate availability of funds – **no** bank holds!

Setup is easy and takes about 5 minutes to complete. Please visit **www.payspanhealth.com/nps** or call your Provider Relations representative or PaySpan **(1-877-331-7154)** with any questions.

We will only deposit into your account, **not** take payments out.

Provider Resources

Provider News – Provider Portal

Remember to check messages regularly to receive new and updated information. Access the secure portal using the *Secure Login* area on our homepage. You will see *Messages from 'Ohana* on the right. Provider Homepage - **www.ohanahealthplan.com/provider**

Resources and Tools

You can find guidelines, key forms and other helpful resources from the homepage as well. You may request hard copies of documents by contacting your Provider Relations representative.

Refer to our Quick Reference Guide, for detailed information on many areas such as Claims, Appeals, Pharmacy, etc. These are located at **www.ohanahealthplan.com/provider**, select *Overview* from the Providers drop-down menu for Medicaid, Medicare and Community Care Services (CCS).

Additional Criteria Available

Please remember that all Clinical Guidelines detailing medical necessity criteria for several medical procedures, devices and tests are available on our website at **www.ohanahealthplan.com/provider**, click on *Tools*.

We're just a phone call or click away!

'Ohana Health Plan, Inc. Medicare: 1-888-505-1201	'Ohana Health Plan, Inc. Medicaid: 1-888-846-4262	www.ohanahealthplan.com/provider

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