Provider Newsletter

'ohana health plan

2023 • Issue 2

Medicaid Redetermination is Resuming This Year

TALK TO YOUR PATIENTS ABOUT CHECKING THEIR ELIGIBILITY.

This year, for the first time since 2020, about 80 million people across the country that are enrolled in Medicaid will have their eligibility redetermined, which may trigger a high risk of coverage losses. Patients may no longer be eligible due to changes in age, household income, and other state-specific criteria.

As a healthcare professional, your patients look to you for expert advice. So be sure to remind them that they are required to verify their eligibility every year or they risk losing their Medicaid coverage. Patients that are enrolled in a Dual Eligible Special Needs Plan (D-SNP), where they receive both Medicaid and Medicare benefits, must also verify their Medicaid eligibility to continue dual coverage.

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In This Issue

'Ohana Health Plan and Wellcare By 'Ohana Health Plan are affiliated products serving Medicaid and Medicare plan members in the State of Hawaii, respectively. The information here is representative of our network of products. If you have any questions, please contact Provider Engagement and Relations.

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wellcare By Ohana Health Plan

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Medicaid Redetermination is Resuming This Year *(continued)*

Let your patients know:

1. They should receive a letter a few months before their Medicaid anniversary date with instructions for verifying their eligibility. They can also check renewal information online.
2. It's very important that they follow through on these instructions or they risk having their coverage canceled.
3. If their eligibility is confirmed, they can continue their existing coverage. If they are no longer eligible for Medicaid, they can explore Marketplace and Medicare options.

For more information about Medicaid redeterminations, please visit **medicaid.gov**.

The COVID-19 Public Health Emergency Ended. What Does That Mean?

On May 11, 2023, the COVID-19 national emergency and public health emergency (PHE) ended.

During the PHE, emergency declarations, legislative actions by Congress, and regulatory actions across government agencies – including those by the Centers for Medicare & Medicaid Services (CMS) – allowed for changes to many aspects of health care delivery. Healthcare providers received maximum flexibility to streamline delivery and allow access to care during the PHE. While some of these changes will be permanent or extended due to Congressional action, some waivers and flexibilities expired, as they were intended to respond to the rapidly evolving pandemic, not to permanently replace standing rules.

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The COVID-19 Public Health Emergency Ended

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What's Affected

- ✓ Certain Medicare and Medicaid waivers and broad flexibilities for health care providers are no longer necessary and will end
- ✓ Coverage for COVID-19 testing, screening and vaccination services will change to reflect members' health plan benefits
- ✓ Providers may need to begin collecting cost shares for certain COVID-19 related services
- ✓ Prior authorization requirements may be reinstated for certain COVID-19 related services
- ✓ Reporting of COVID-19 laboratory results and immunization data to CDC will change
- ✓ Certain Food and Drug Administration (FDA) COVID-19-related guidance documents for the industry that affect clinical practice and supply chains will end or be temporarily extended
- ✓ FDA's ability to detect early shortages of critical devices related to COVID-19 will be more limited
- ✓ The ability of health care providers to safely dispense controlled substances via telemedicine without an in-person interaction will change; however, there will be rulemaking that will propose to extend these flexibilities

What is Not Affected

- ✓ FDA's emergency use authorizations (EUAs) for COVID-19 products (including tests, vaccines, and treatments)
- ✓ Access to COVID-19 vaccinations and certain treatments, such as Paxlovid and Lagevrio
- ✓ Major Medicare telehealth flexibilities
- ✓ Medicaid telehealth flexibilities
- ✓ The process for states to begin eligibility redeterminations for Medicaid
- ✓ Access to buprenorphine for opioid use disorder treatment in Opioid Treatment Programs (OTPs)
- ✓ Access to expanded methadone take-home doses for opioid use disorder treatment

The Health Plan is committed to providing a smooth transition for both our members and providers as we resume business as usual. While we will continue to communicate any updates to our business practices directly to our provider partners, we always highly recommend that providers verify member eligibility, benefits, and prior authorization requirements before rendering services.

References:

1. *"Fact Sheet: COVID-19 Public Health Emergency Transition Roadmap," retrieved from: https://www.hhs.gov/about/news/2023/02/09/fact-sheet-covid-19-public-health-emergency-transition-roadmap.html*
2. *"CMS Waivers, Flexibilities, and the Transition Forward from the COVID-19 Public Health Emergency," retrieved from: https://www.cms.gov/newsroom/fact-sheets/cms-waivers-flexibilities-and-transition-forward-covid-19-public-health-emergency#:~:text=Based%20on%20current%20COVID%2D19,day%20on%20May%2011%2C%202023*

Annual NCQA Accreditation Coming Soon!

We will be providing important annual information for practitioners to review regarding National Committee for Quality Assurance (NCQA) accreditation. This information will help keep practitioners informed about NCQA accreditation requirements to ensure the best care for our members. Topics include updating the provider directory, utilization management decisions, pharmacy, language services, access to case management, appointment access standards, and member rights and responsibilities, among others.

Stay tuned for more to come!

Engaging Your Patients in Medication Adherence Discussions

According to the American Medical Association (AMA), patients only take their medications half of the time. Adherence is defined as a patient who takes their medications at least 80% of the time, and with the current rate of 50% adherence in the general public, this is an area worth addressing. To combat this lack of adherence, engaging with your patients is essential.

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Engaging Your Patients in Medication Adherence Discussions *(continued)*

Below are some tips on how to assess for medication adherence in your patient.

1. Create a routine by asking ***every*** patient about their adherence to medications.
2. Ask open ended questions:
   - Can you tell me how you are taking this medication?
   - What do you think about this medication?
   - How do you remember to take your medicine?
3. Ask the patient about barriers that hinder them from taking their medication:
   - What bothers you about this medication?
   - What stands in the way of you taking your medicine?
4. Offer a supportive, non-judgmental atmosphere by utilizing motivational interviewing:
   - Listen to the patients concerns.
   - Ask the patient about their health goals.
   - Avoid arguments and adjust to resistance.
   - Support optimism and give encouragement.
   - Understand and respect patient values and beliefs.

5. If the patient states they are non-adherent, thank them for sharing before continuing to assess.
6. Develop a plan to address barriers the patient is experiencing and involve the patient in your decisions. One way to do this is to offer clinically-appropriate options for them to choose from.
   - Utilize the word "we."
   - We can try option one or option two. What do you think about these options? Which of these do you think best suits you?

We value everything you do to deliver quality care to our members – your patients. Thank you for playing a role in assessing and improving medication adherence in your patients.

References:

1. *AMA Ed Hub and Society of General Internal Medicine, "Medication Adherence Improve Patient Outcomes and Reduce Costs," retrieved from: https://edhub.ama-assn.org/steps-forward/module/2702595*
2. *AMA. "Nudge theory explored to boost medication adherence," retrieved from: https://www.ama-assn.org/delivering-care/patient-support-advocacy/nudge-theory-explored-boost-medication-adherence*
3. *Treatment Improvement Protocols Series, "Chapter 3-Motivational Interviewing as a Counseling Style," retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK64964/*
4. *American Association of Diabetes Educators, "Fostering Medication Adherence Tips and Tricks," retrieved from: https://www.diabeteseducator.org/docs/default-source/living-with-diabetes/tip-sheets/medication-taking/fostering_med_adherence.pdf?sfvrsn=4*

The Importance of Substance Use Disorder Treatment

According to the Substance Abuse and Mental Health Service Administration (SAMHSA), substance use disorder (SUD) treatment can help individuals' stop or reduce harmful substance misuse, improve patients' overall health, social functioning, and ways to manage risk for potential relapse. Timely intervention and treatment can increase productivity, health, and overall quality of an individual's life and have a positive economic impact, as every dollar spent on treatment saves four dollars in healthcare and seven dollars in criminal justice costs.[1]

Individuals may receive this primary SUD diagnosis in several types of settings by primary care physicians (PCP), medical specialists, and behavioral health professionals. This includes inpatient acute medical and psychiatric facilities, inpatient or outpatient withdraw management programs, emergency rooms, medical assessments conducted by a PCP or medical specialist, and outpatient mental health treatment.

One barrier to treatment is an individual's denial of their illness, particularly newly diagnosed persons with primary SUD that have long-term chronic use or dependence, as this could prevent individuals from achieving successful treatment and recovery. Whether it is a singular SUD primary diagnosis, or comorbid medical and/or mental health diagnoses, there are best practices to address barriers and improve the quality of care for at-risk member populations.

Various HEDIS® measures integrate best practice treatment recommendations for successful outcomes of individuals diagnosed with primary SUD.[2]

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The Importance of Substance Use Disorder Treatment *(continued)*

Initiation and Engagement of Substance Use Disorder Treatment (IET) Measure

Members diagnosed with a new primary SUD diagnosis occurring as part of an inpatient medical or psychiatric hospitalization, PCP visit, a medical specialist consultation, or a behavioral health evaluation are included in this measure.

SAMHSA endorses Screening, Brief Intervention, and Referral to Treatment (SBIRT) as an effective evidence-based screening tool. The SBIRT can be administered by primary care centers, hospital emergency rooms, trauma centers, and other community settings.

To improve health outcomes related to SUD treatment, once an individual 13 years and older is diagnosed, it is important to start treatment within 14 days of the primary SUD diagnosis as a best practice. Upon completion of initiating treatment, ongoing treatment can improve better outcomes by ensuring the individual has two follow-up SUD appointments within 34 days of the initial visit. Visits can occur with any practitioner with a documented diagnosis of alcohol use, opioid use, or other related substance use disorder.

Follow-Up After Emergency Department Visit for Substance Use (FUA) Measure

Individuals 13 and older admitted to an emergency department (ED) may be assessed by the ED physician, receive a medical consultation, or a behavioral health evaluation. All healthcare providers may deliver an SUD diagnosis.

Patients discharged from the ED following high-risk substance use events are particularly vulnerable to losing contact with the healthcare system. Care coordination is an important way to improve how the healthcare system works for patients, especially in terms of improved efficiency and safety.[3]

Timely follow-up within seven, but no more than 30 days, of the ED discharge are proven to improve patient outcomes. Visits can occur in various settings or via telehealth and with any practitioner for a diagnosis of SUD or drug overdose, a pharmacotherapy dispensing event, or with an approved mental health provider.

Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) Measure

Best practices for individuals 13 years and older diagnosed with SUD who are preparing for discharge from an acute inpatient medical, mental health, or substance use facility, residential treatment, or withdrawal management (detoxification) event includes a follow-up appointment within seven days after the individuals' discharge date.

Aftercare can occur with any practitioner for a principal diagnosis of SUD during an outpatient visit, telehealth visit, intensive outpatient visit, partial hospitalization, or medication assisted treatment appointments. If follow-up does not occur within seven days, it should occur no more than 30 days after discharge.

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The Importance of Substance Use Disorder Treatment *(continued)*

Key recommendations for successful outcomes:

- ✓ Substance use screenings and early intervention can positively affect successful outcomes.
- ✓ Engagement in treatment. Encourage your patients and their identified support to take part in treatment planning and future treatment.
- ✓ Supply available community resources and support, such as 12-step programs, peer support groups, available housing, transportation, food resources, and legal services.
- ✓ Encourage your patients' self-management of their recovery.
- ✓ Take a holistic team approach to your patients' recovery by involving family and friends along with their treating PCP, medical specialist, and behavioral health specialist to address social, medical, and/or mental health challenges individuals in recovery may face.
- ✓ Provide integrated/coordinated care between the physical and behavioral health providers to address any comorbidity.
- ✓ Provide prompt submission of claims and code substance-related diagnoses and visits correctly.
- ✓ Offer telehealth and same-day appointments.

A treatment plan that includes a prompt referral for evaluation at the time of the primary SUD diagnosis with prescribed ongoing treatment can improve the long-term health and wellness for this at-risk member population.

References:

1. *(US), Substance Abuse and Mental Health Services Administration; (US)., Office of the Surgeon General. (2016, Nov). Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Retrieved from ncbi.nlm.nih.gov: https://www.ncbi.nlm.nih.gov/books/NBK424859/*
2. *Agency for Healthcare Research and Quality. (2018, Aug). Care Coordination. Retrieved from Agency for Healthcare Research and Quality: https://www.ahrq.gov/ncepcr/care/coordination.html*
3. *National Committee for Quality Assurance. (2022). HEDIS® and performance measurement. Retrieved from NCQA.org: https://www.ncqa.org/HEDIS/*

Special Supplemental Benefits for the Chronically Ill Attestation – Important Process Change

Effective January 1, 2023, the process to determine Medicare Advantage member special supplemental benefit eligibility and chronically ill attestation requirements changed from a fax to an online system through **ssbci.rrd.com**.

Medicare members are required to schedule an office visit with their provider for evaluation. Once an appointment is made, follow these steps:

Visit **ssbci.rrd.com**.

Follow the steps on **ssbci.rrd.com** to evaluate your patient against the eligibility requirements outlined.

Submit an attestation form through **ssbci.rrd.com** indicating your patient meets the eligibility requirements.

Submit a claim containing the appropriate diagnosis codes from this office visit indicating a member has been diagnosed with one or more qualifying chronic conditions listed on **ssbci.rrd.com**.

Upon receipt of all required information, the member will be sent an **approval or denial letter within 10 business days**. Approval letters include information on steps the member should follow to activate supplemental member benefits.

2023 Partnership for Quality Provider Incentive Program Unveiled

To incentivize providers to drive care-gap closure among our Medicare Advantage members and continue the quality care they deliver, we launched the 2023 Medicare Partnership for Quality (P4Q) Primary Care Provider Incentive Program.

Most notably, this year's program increases incentives compared to the 2022 program to better align with quality performance.

Providers can now potentially earn a 50% bonus increase by achieving an aggregate Healthcare Effectiveness Data and Information Set (HEDIS) and pharmacy star rating of 4.0 or higher across HEDIS and medication adherence measures for calendar year 2023.

Incentive payments earned through the P4Q program will be in addition to the compensation arrangement set forth in a provider's participation agreement, as well as any other incentive program in which they may participate.

To learn more or to inquire about eligibility, please reach out to your provider relations representative.

The Importance of Quality Care

QUALITY IS OUR PRIORITY.

We want our members to get the best care and the information they need to optimize their health. Each year, we set goals to improve the quality of our members' healthcare. It's part of our Quality Improvement (QI) Program. We have a Quality Improvement and Utilization Management Committee chaired by Vincent Nelson, Senior Vice President and Deputy Chief Medical Officer- Medical Affairs, that meets at least eight times per year to review Quality programs and initiate actions where needed.

In 2022, we took these steps:

- ✓ Monitored our members' satisfaction with you, their doctors.
- ✓ Assisted with the coordination of care to help members understand their medications, follow up with their doctor's appointments, and communicate with their care givers. This led to significant improvements in medication adherence for our diabetic members in our Dual Special Needs (D-SNP) plans.
- ✓ Continued regular review of quality outcome data to ensure our members are getting high quality care and made significant advancements in performance with our diabetic D-SNP members.
- ✓ Increased self-service tools for our members to use to order member materials, see medication lists and, in some cases, order prescriptions, see a list of wellness services, find doctors and urgent care centers, complete health assessments, and participate in incentive programs.
- ✓ Supported safe options for face-to-face contact with members primary care providers at least annually so they can maintain better health.

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The Importance of Quality Care *(continued)*

In 2023, we will:

- ✓ Offer more, and easier, ways for our members, to complete health assessments so they can get needed care when it can do the most good.
- ✓ Continue regular review of quality outcome data to improve services and care.
- ✓ Conduct member engagement activities to gain feedback from our members on ways to better serve them.
- ✓ Continue to expand provision of high-quality customer service in different languages and easy access to TTY services for our hearing-impaired members.
- ✓ Communicate any changes to coverage of members' prescribed medications that might impact them annually so our members and their doctors can stay informed.
- ✓ Offer more ways to support the health and wellbeing of our members by increased support of our care managers and community resource workers, as well as provide support throughout an episode of care should they need an acute or emergent facility.
- ✓ Continue to improve our education and services for our members to stay in control of their chronic conditions, such as diabetes and hypertension.

To learn more about our Quality Improvement Program, please email **AccreditationMedicareOperations@Centene.com** for a copy of our Medicare Quality Improvement and Utilization Management Annual Program Evaluation, including our Special Needs Model of Care Program Evaluation, or request to become a part of the Quality Improvement and Utilization Management Committee.

**All Medicare markets except Health Net California & Fidelis NY*

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 Provider Relations 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:

Mail:

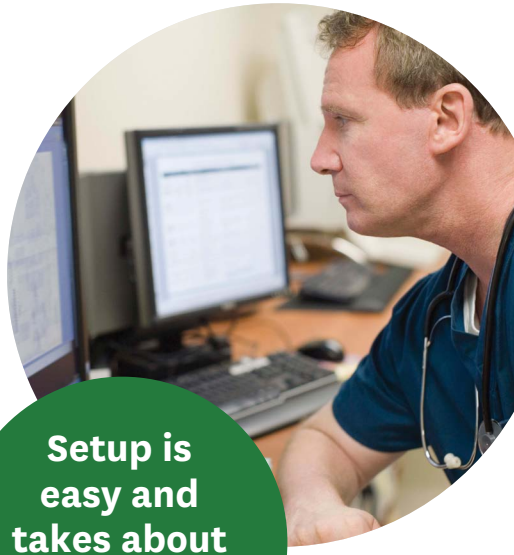
ʻOhana Health Plan
ATTN: Provider Operations
820 Mililani Street, Suite 200
Honolulu, HI 96813

Fax:

1-866-788-9910

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

Electronic Funds Transfer (EFT) Through PaySpan®



Setup is easy and takes about 5 minutes to complete.

FIVE REASONS TO SIGN UP TODAY FOR EFT:

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

Please visit **www.payspanhealth.com/nps** or call your Provider Relations representative or PaySpan at **1-877-331-7154** with any questions. We will only deposit into your account, **not** take payments out.

Provider Formulary Updates

There have been updates to the QUEST Integration Preferred Drug List (PDL) and the Medicare Formulary. Visit our websites listed below to view the current PDL and pharmacy updates. You can also refer to the *Provider Manual*, also available on our websites, to view more information on the plan'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.ohanahealthplan.com/providers/medicaid/community-care-services.html** to view more information on our pharmacy UM policies and procedures.

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 home page. You will see Messages from the plan on the right.

Remember, you can check the status of authorizations and/or submit them online. You can also chat with us online instead of calling.

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 (QRG)* for detailed information on areas including Claims, Appeals and Pharmacy. The *Provider Manual* and *QRG* are located at these websites, under *Overview* and *Resources*.

- ʻOhana Health Plan: **ohanahealthplan.com/providers.html**
- Wellcare By ʻOhana: **wellcare.com/Hawaii/Providers**

Additional Criteria Available

Please remember that all Clinical Guidelines detailing medical necessity criteria for several medical procedures, devices and tests are also available on our websites, click on *Tools*.

Contact Us

If you have questions about the utilization management program, please call Provider Services at one of the numbers below. TTY 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. There is no charge for this.

We're Just a Phone Call or Click Away

ʻOhana Health Plan (Medicaid):
1-888-846-4262

Wellcare By ʻOhana (Medicare):
1-888-505-1201

ʻOhana Health Plan:
ohanahealthplan.com/providers.html

Wellcare By ʻOhana:
wellcare.com/Hawaii/Providers