Hawai`i

Provider Newsletter

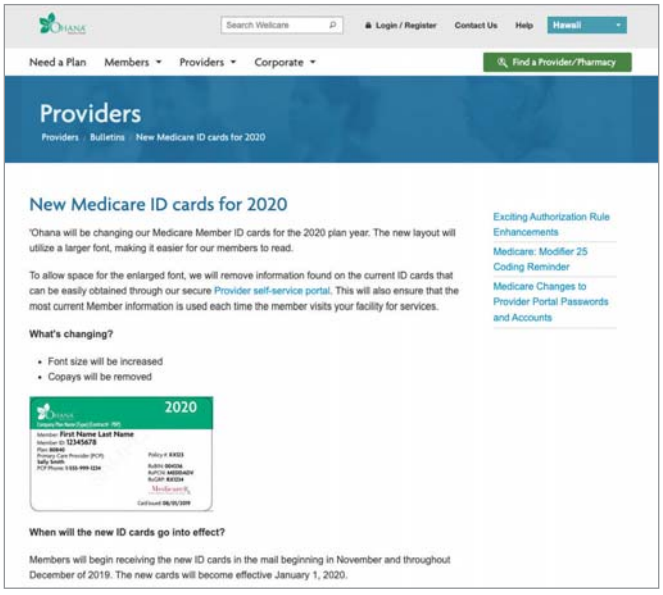
2020 • Issue I

Quality

New Medicare ID cards for 2020

'Ohana changed our Medicare Member ID cards for the 2020 plan year. The new layout utilizes a larger font, making it easier for our members to read. Learn what else has changed.

http://www.wellcare.com/HICare2020ID



In This Issue

Quality

Operational

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

'Ohana Health Plan

Med-QUEST Issues Letter on Electronic Visit Verification System

The Med-QUEST Division (MQD) recently issued a letter to providers about the new Electronic Visit Verification (EVV) system. Medicaid providers of home health agency services and home and community-based services will be required to use Electronic Visit Verification starting later this year. EVV is an electronic-based system that verifies when and where provider visits occur and documents the precise time services begin and end. It ensures that members receive their authorized services.

Participation in the EVV implementation is mandatory for the following programs:

- QUEST Integration (1115 waiver) program
- I/DD (1915(c) waiver)

You can read the complete letter online at: **https://www.wellcare.com/en/Hawaii/Providers/Medicaid**

Improving Patient Satisfaction and CAHPS Scores

What is the CAHPS?

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey asks patients to evaluate their health care experiences. ‘Ohana Health Plan conducts an annual CAHPS survey, asking members to rate experiences with their healthcare providers and plans. As a ‘Ohana Health Plan provider, you can provide a positive experience on key aspects of their care. We have provided some examples of best practice tips to help with each section.

Know What You Are Being Rated On

Getting Needed Care	• Ease of getting care, tests, or treatment needed. • Obtained appointment with specialist as soon as needed. • Help patients by coordinating care for tests or treatments, and schedule specialists appointments, or advise when additional care is needed to allow time to obtain appointments.
Getting Care Quickly	• Obtained needed care right away. • Obtained appointment for care as soon as needed. • How often were you seen by the provider within 15 minutes of your appointment time? • Educate your patients on how and where to get care after office hours. • Do you have on-call staff? Let your patients know who they are.
How Well Doctors Communicate	**Doctor explained things in way that was easy to understand** • Doctor listened carefully. • Doctor showed respect. • Child’s doctor spent enough time with your child. • The simple act of sitting down while talking to patients can have a profound effect. • Ask your patients what is important to them; this helps to increase their satisfaction with your care.

Shared Decision Making	• Doctor/health care provider talked about reasons you might want your child to take a medicine. • Doctor/health care provider talked about reasons you might not want your child to take a medicine. • Doctor/health care provider asked you what you thought was best for your child when starting or stopping a prescription medicine. • Use of office staff other than physicians to distribute decision aids could help more patients learn about the medical decisions they are facing or simply to address medications. • Innovations, quality tools and other content on shared decision making are available at: **https://innovations.ahrq.gov/** • Ask your patients, "What should I know about you that may not be on your medical chart?"
Coordination of Care	• In the last 6 months, did your personal doctor seem informed and up-to-date about the care you got from other health providers? • Your office staff should offer to help your patients schedule and coordinate care between providers.
Rating of Personal Doctor	Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor? • Studies have shown that patients feel better about their doctor when they ask their patients, "What's important to you?"
Rating of Specialist	• Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist? • Help your members value their visit to the specialists. Be informed of their visit and their advice.

What This Means: Tips to Increase Patient Satisfaction:

Make sure both you and your medical team know the questions your practice is being rated on. Knowledge is power.

Source:

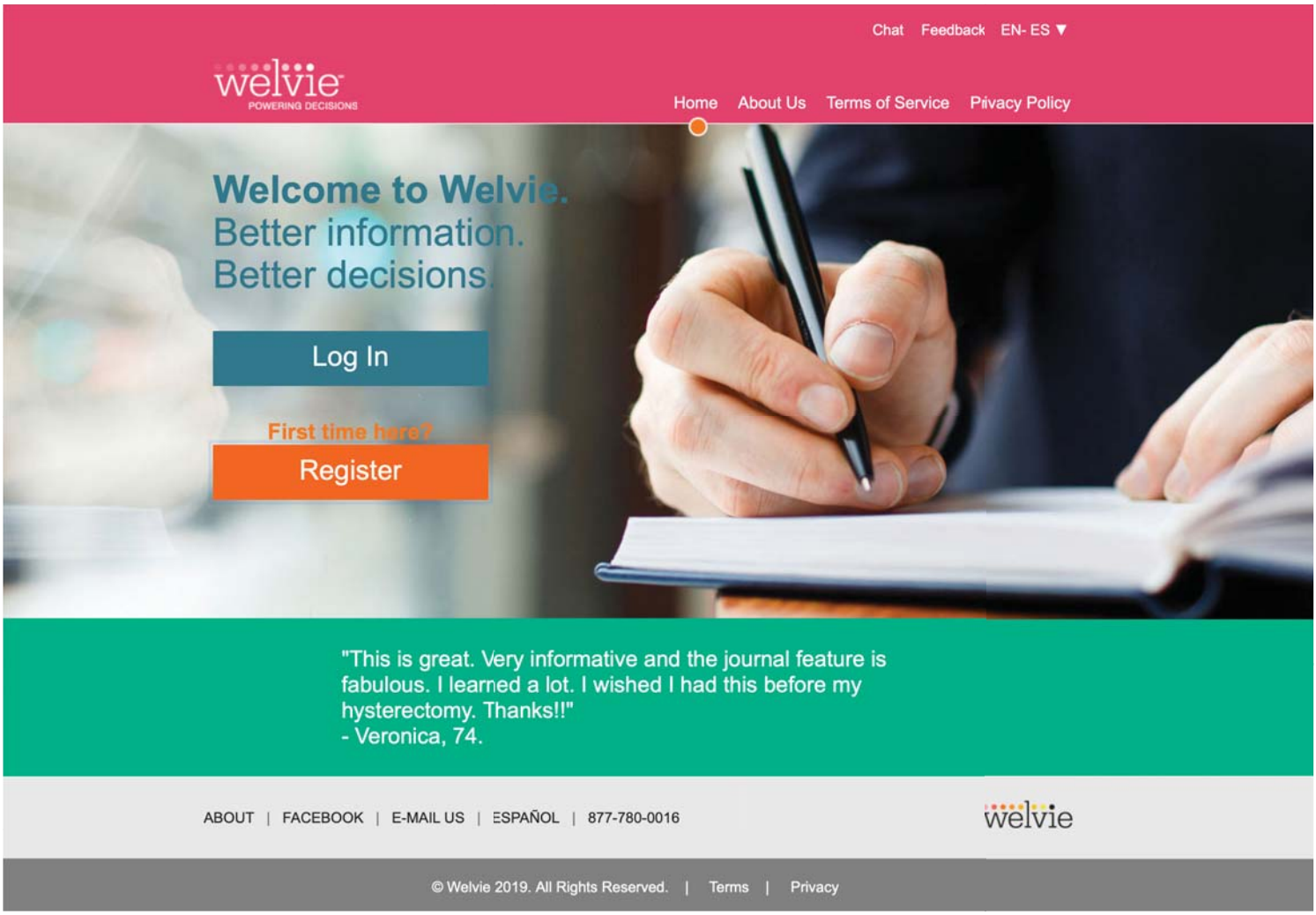
2019 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

Quality

2019 CAHPS Results

Below are the results of the 2019 Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

Adult CAHPS Measures	Medicaid		Medicare	
	Score	NCQA Percentile	Score	Star Rating
Getting Needed Care	81.8%	40th Percentile	77.9%	★★
Getting Care Quickly	81.1%	33rd Percentile	72.3%	★★
Coordination of Care	83.5%	51st Percentile	83.7%	★★★
Rating Items (8-10)				
Rating of Health Care	73.8%	39th Percentile	81.6%	★★
Rating of Personal Doctor	79.5%	28th Percentile	88.9%	★★★
Rating of Specialist	86.6%	90th Percentile	89.6%	★★★



Welvie®: Improving Members' Health Care Experience

In 2015, 'Ohana began offering the Welvie online surgery shared-decision making program to its **Medicare Advantage members**.

Welvie's six-step program curriculum helps participants decide on, prepare for and recover from surgery. Through information, Q&As and videos, patients learn how to work with their doctors to explore treatment options – both surgical and non-surgical – when considering "preference-sensitive" surgeries like spine fusion, knee arthroscopy, prostatectomy and other elective procedures. Preference-sensitive surgeries are defined as those that have two or more viable alternatives for a presenting condition. If the patient, along with their doctor, decides surgery is right for them, Welvie then helps patients prepare for surgery and recovery with robust tools including checklists, calendars and other information and helpful tips to help them have error- and complication-free results.

Welvie participants receive a $25 Amazon.com gift card for completing the first three steps of the program (reward is available once per member per 365 days).

The program's goal is to support member/physician interaction and preparation for surgery, as well as to promote improved health literacy.

After three years, the program has received high satisfaction marks from members. 96% of 'Ohana members have reported they felt the Welvie program helped them speak with their doctor about their treatment options and 97% said the Welvie program better prepared them for surgery.

To refer your **'Ohana Medicare Advantage** patients to Welvie, just send them to **www.welvie.com** to register and engage in the program.

Availability of Criteria

The review criteria and guidelines are available to the providers upon request. Providers may request a copy of the criteria used for specific determination of medical necessity by calling the Customer Services department:

HI Care: 1-888-505-1201	HI Caid: 1-888-846-4262

Also, 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.wellcare.com/Provider/CCGs**.

Operational

Access to Staff

If you have questions about the Utilization Management program, please call Customer Service at **1-888-846-4262**. 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.

Emergency Room Evaluation and Management (E&M)

'Ohana is committed to continuously improving its claims review and payment processes. This is to notify you that effective **8/25/2020**, we will begin applying coding edit guidelines for the appropriate coding of Emergency Room Evaluation and Management (E&M) code levels based on 'Ohana Emergency Room E&M Program.

Both Centers for Medicare & Medicaid Services (CMS) and the Office of Inspector General (OIG) have documented that Emergency Room E&M services are among the most likely services to be incorrectly coded, resulting in improper payments to practitioners. The OIG has also recommended that payers continue to help to educate practitioners on coding and documentation for Emergency Room E&M services, and develop programs to review E&M services billed for by high-coding practitioners.

Overview of 'Ohana Emergency Room E&M Program;

- Evaluates and reviews high-level Emergency Room E&M services for high-coding practitioners, which appear to have been incorrectly coded based upon diagnostic information that appears on the claim, and peer comparison.
- Applies the relevant Emergency Room E&M policy and recoding of the claim line to the proper Emergency Room E&M level of service.
- Allows reimbursement at the highest Emergency Room E&M service code level for which the criteria is satisfied based on our risk adjustment process.

Providers should report Emergency Room E&M services in accordance with the American Medical Association's (AMA's) CPT Manual and the Centers for Medicare and Medicaid Services (CMS') guidelines for billing Emergency Room E&M service codes; "Documentation Guidelines for Evaluation and Management". The proper reporting of Emergency Room E&M Services enables 'Ohana to more precisely apply reimbursement-coding guidelines and ensure that an accurate record of patient care history is maintained.

Determinations as to whether services are reasonable and necessary for an individual patient should be made on the same basis as all other such determinations – with reference to accepted standards of medical practice and the medical circumstances of the individual case.

Thank you for your cooperation. If you have any questions or need more information, please contact your Provider Relations representative.

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
ATTN: Provider Operations
949 Kamokila Blvd., Suite 350
Kapolei, HI 96707

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

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:

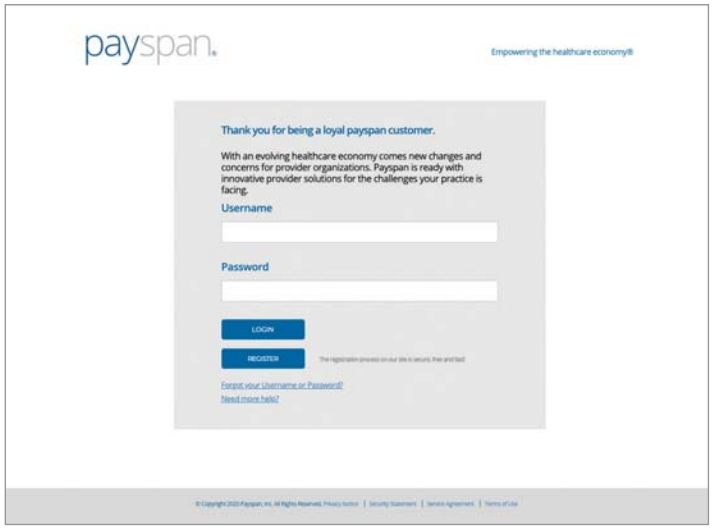
Updates have been made to the Medicare Formulary. Find the most up-to-date complete formulary at **www.ohanahealthplan.com/provider**, and click *Pharmacy* under Medicare icon.

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.

Electronic Funds Transfer (EFT) through PaySpan®

Five reasons to sign up today for EFT:

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



Setup is easy and takes about five minutes to complete. 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.

We're Just a Click or Phone Call Away

www.ohanahealthplan.com/provider | **Medicare: 1-866-319-3554** | **Medicaid: 1-888-846-4262**

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 'Ohana on the right. Provider Homepage – **www.ohanahealthplan.com/provider**. **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* for detailed information on areas including Claims, Appeals and Pharmacy. 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 at **www.ohanahealthplan.com/provider**, click on Tools.