Provider Newsletter
Hawai'i

2021 • Issue 3

Medicaid • Medicare

Member and Provider Survey Results on Behavioral Health Services

'OHANA HEALTH PLAN APPRECIATES ALL THAT YOU DO IN PROVIDING QUALITY CARE AND SERVICES FOR OUR MEMBERS.

We conduct annual surveys to assess member experiences and perceptions with their provider and health plan using a survey program called CAHPS® (Medical focused survey for adults and children) and BH ECHO® (Behavioral Health service focused survey for adults). This feedback helps us improve our quality and member experience.

The BH Echo survey includes adults who briefly received a behavioral health screening or assessment at their Primary Care Provider (PCP) visits. This includes visits for their regular treatment.

(continued on next page)

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.

Member and Provider Survey Results on Behavioral Health Services Continued

Here are some of the results of the BH ECHO® survey:

Members were *Satisfied/Very Satisfied* (responded *Usually* or *Always*) in the following areas of the services you have provided:

- ✓ Getting Treatment Quickly – Able to access treatment as soon as they wanted.
- ✓ How Well Clinicians Communicate – Listened to them carefully and they were involved in their treatment and counseling as much as they wanted
- ✓ Informed about Treatment Options – Given information about different kinds of counseling or treatment that are available

Areas where patients felt that more attention was needed:

- ✓ To provide more information about what they can do to manage their condition
- ✓ To improve overall rating of counseling and treatment
- ✓ To improve waiting time - from the time they check in until the time they see you has been longer than 30 minutes

This year, ‘Ohana Health Plan will focus on improving the survey participation rate, sharing the results and expanding access for behavioral health services further through telehealth service in our network.

Thanks to you, patients with better care experiences often have better health outcomes by adhering to treatment plans.[1] **We value your partnership and look forward to working together to provide the best care possible for your patients, our members.**

Resources:
Stewert M A. Effective physician-patient communication and health outcomes: a review. CMAJ. 1995. Retrieved from: https://pubmed.ncbi.nlm.nih.gov/7728691/

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 treatments 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 health care 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

Remember to view the online Provider Bulletins regularly for important updates and notices. Provider bulletins are located at **www.ohanahealthplan.com/en/Hawaii/Providers/Bulletins**

Coordination of Care

HERE ARE MORE TIPS TO PROVIDE THE NEEDED CARE FOR YOUR PATIENTS:

- ✓ Review medications with your patients.
- ✓ Remind your patients about annual flu shots and other immunizations.
- ✓ 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
- ✓ Offer to schedule specialist and lab appointments while your patients are in the office.
- ✓ 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.

Immunizations & Well-Child Checkups

Immunizations and Well-Child Checkups Providers play a key role in establishing and maintaining a practice-wide commitment to communicating effectively about vaccines and maintaining high vaccination rates, including providing educational materials and making themselves available to answer questions.

Parents who are confused or have misperceptions about disease risk and safety may delay or refuse immunizations for their children.

A successful discussion about vaccines involves a two-way conversation with both parties sharing information and asking questions. These communication principles can help you connect with patients and their caretakers by encouraging open, honest and productive dialogue.

Here are two ways you can lead this discussion:

1. Educate parents on how to prevent the spread of disease.

2. Remind parents of the value of comprehensive well-child checkups and staying on schedule with immunizations.

Remember, you may complete a comprehensive well-child checkup during a sick child visit or sports physical if the member is due for a checkup.

Source: Recycled from 2018 Provider Newsletter Q2

2021 Medicaid Behavioral Health Bonus Program Announcement

At ʻOhana we understand that the provider-member relationship is a key component in ensuring superior healthcare and the satisfaction of our members. **Because ʻOhana recognizes these important partnerships, we have developed the 2021 Behavioral Health Bonus Program to reward eligible Behavioral Health practitioners for providing specific services listed in the table below.**

- Behavioral Health providers must submit a claim/encounter containing the requisite diagnosis and/or procedure codes to receive the bonus payment for eligible members.
- These bonus rewards are applicable to services rendered to members with ʻOhana Health Plan QUEST Integration. The services rendered to members enrolled in ʻOhana QUEST Integration coverage in conjunction with Medicare and/or CCS coverage will not be eligible for this bonus program.
- A follow-up visit with a mental health provider within 7 days after discharge. Do not include visits that occur on the date of discharge.
- Service must be rendered from January 8, 2021 to December 8, 2021.
- All claims/encounters must be submitted by January 31, 2022, to be used in calculating the final payment.
- A one-time payment will be issued in 2022 after the end of the program year.
- ʻOhana may request medical records if unable to verify care using claim/encounter data.

Measure and Bonus Amount:

Measure	Amount
Follow-up after Hospitalization for Mental Illness – 7 Days	**$30**

Instructions:

1. Schedule and conduct an exam with the member by December 8, 2021, to address the program measure(s).
2. Upon completion of the appointment, document care and diagnosis in the patient's medical record and submit the claim/encounter containing all relevant ICD 10, CPT and/or CPT II codes by January 31, 2022.

Questions?

If you have questions about Behavioral Health Bonus Program, please contact your Provider Relations Representative, Quality Practice Advisor or call Provider Services at **1-888-846-4262** (TTY 711).

You can reach us Monday–Friday from 7:45 a.m. to 4:30 p.m. Hawai'i Standard Time (HST).

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2021 Medicaid Behavioral Health Bonus Program Announcement Continued

Additional Conditions:

To be eligible to receive a bonus payment under this Program, Behavioral Health Providers must meet the following requirements and/or conditions:

1. All Providers must:
   (a) Be in a participation Agreement with ‘Ohana, either directly or indirectly through a Vendor, from the Effective Date and continually through the dates the bonus payments are made, and
   (b) Be in compliance with their participation Agreement including the timely completion of required training or education as requested or required by ‘Ohana.
2. Bonus payments are paid to the eligible ‘Ohana Health Plan Quest Integration member’s Behavioral Health Provider of record at the end of the applicable measurement periods as defined by the HEDIS® specifications. Bonus rewards are not applicable to services rendered to members who are enrolled in Medicare and/or CCS coverage in conjunction with ‘Ohana QUEST Integration coverage.
3. Any bonus payments earned through this Program will be in addition to the compensation arrangement set forth in your participation Agreement, as well as any other ‘Ohana bonus program in which you may participate. At ‘Ohana’s discretion, Providers who have a contractual or other quality bonus arrangement with ‘Ohana either directly or through an IPA/Vendor may be excluded from participation in this Program.
4. The terms and conditions of the participation Agreement, except for appeal and dispute rights and processes, are incorporated into this Program, including without limitation, all audit rights of ‘Ohana, and the Provider agrees that ‘Ohana or any state or federal agency may audit his/her/its records and information.
5. The Program is discretionary and subject to modification due to changes in government healthcare program requirements, or otherwise. ‘Ohana will determine if the requirements are satisfied and payments will be made solely at ‘Ohana’s discretion. There is no right to appeal any decision made in connection with the Program. If the Program is revised, ‘Ohana will send a notice to Provider by email or other means of notice permitted under the participation Agreement.
6. ‘Ohana reserves the right to withhold the payment of any bonus that may have otherwise been paid to a Provider to the extent that such Provider has received or retained an overpayment (any money to which the Provider is not entitled, including, but not limited to, Fraud, Waste or Abuse) from ‘Ohana, or ‘Ohana’s Eligible Member. In the event ‘Ohana determines a Provider has been overpaid, ‘Ohana may offset any bonus payment that may have otherwise been paid to the Provider against overpayment.
7. Only one bonus payment will be made for a specific HEDIS® member-measure combination. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
8. ‘Ohana shall make no specific payment, directly or indirectly under a provider bonus program, to a Provider as an inducement to reduce or limit medically necessary services to an enrollee, and this Program does not contain provisions that provide bonuses, monetary or otherwise, for withholding medically necessary care. All services should be rendered in accordance with professional medical standards.

2021 Medicaid OB/GYN Incentive Program Announcement

At ʻOhana we understand that the provider-member relationship is a key component in ensuring superior healthcare and the satisfaction of our members. **Because ʻOhana recognizes these important partnerships, we have developed the 2021 OB/GYN Incentive Program to reward eligible OB/GYN practitioners for providing specific services listed in the table below.**

- OB/GYN providers must submit a claim/encounter containing the requisite diagnosis and/or procedure codes to receive the bonus payment for eligible members
- Services must be rendered to eligible members by December 31, 2021.
- All claims/encounters must be submitted by Jan. 31, 2022, to be used in calculating the final payment
- A one-time payment will be issued in 2022 after the end of the program year.
- ʻOhana may request medical records if unable to verify care using claim/encounter data.

Instructions:

1. Schedule and conduct an exam with the member by December 31, 2021, to address the program measure(s).
2. Upon completion of the examination, document care and diagnosis in the patient's medical record and submit the claim/encounter containing all relevant ICD 10, CPT and/or CPT II codes by Jan. 31, 2022.

Questions?

If you have questions about OB/GYN Incentive Program, please contact your Provider Relations Representative, Quality Practice Advisor or call Provider Services at **1-888-846-4262** (TTY **711**).

You can reach us Monday–Friday from 7:45 a.m. to 4:30 p.m. HST

Measure and Bonus Amount:

Measure	Amount
Postpartum Visit	**$40**
Prenatal Visit (Timeliness)	**$40**

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2021 Medicaid OB/GYN Incentive Program Announcement Continued

Additional Conditions:

To be eligible to receive a bonus payment under this Program, OB/GYN Providers must meet the following requirements and/or conditions:

1. All Providers must:
   (a) be in a participation Agreement with ʻOhana, either directly or indirectly through a Vendor, from the Effective Date and continually through the dates the bonus payments are made, and
   (b) be in compliance with their participation Agreement including the timely completion of required training or education as requested or required by ʻOhana.
2. Bonus payments are paid to the Eligible Member's OB/GYN Provider of record at the end of the applicable measurement periods as defined by the HEDIS® specifications.
3. Any bonus payments earned through this Program will be in addition to the compensation arrangement set forth in your participation Agreement, as well as any other ʻOhana incentive program in which you may participate. At ʻOhana's discretion, Providers who have a contractual or other quality incentive arrangement with ʻOhana either directly or through an IPA/Vendor may be excluded from participation in this Program.
4. The terms and conditions of the participation Agreement, except for appeal and dispute rights and processes, are incorporated into this Program, including without limitation, all audit rights of ʻOhana, and the Provider agrees that ʻOhana or any state or federal agency may audit his/her/its records and information.
5. The Program is discretionary and subject to modification due to changes in government healthcare program requirements, or otherwise. ʻOhana will determine if the requirements are satisfied and payments will be made solely at ʻOhana's discretion. There is no right to appeal any decision made in connection with the Program. If the Program is revised, ʻOhana will send a notice to Provider by email or other means of notice permitted under the participation Agreement.
6. ʻOhana reserves the right to withhold the payment of any bonus that may have otherwise been paid to a Provider to the extent that such Provider has received or retained an overpayment (any money to which the Provider is not entitled, including, but not limited to, Fraud, Waste or Abuse) from ʻOhana, or ʻOhana's Eligible Member. In the event ʻOhana determines a Provider has been overpaid, ` Ohana may offset any bonus payment that may have otherwise been paid to the Provider against overpayment.
7. Only one bonus payment will be made for a specific HEDIS® member-measure combination. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
8. ʻOhana shall make no specific payment, directly or indirectly under a provider incentive program, to a Provider as an inducement to reduce or limit medically necessary services to an enrollee, and this Program does not contain provisions that provide incentives, monetary or otherwise, for withholding medically necessary care. All services should be rendered in accordance with professional medical standards.

2021 Medicaid Partnership for Quality (P4Q) Program Announcement

At ʻOhana Health Plan, we understand that the provider-member relationship is a key component in ensuring superior health care and the satisfaction of our members. **Because ʻOhana recognizes these important partnerships, we have developed the 2021 P4Q Program to reward primary care providers (PCPs) for submitting documentation for HEDIS Measures (ICD 10, CPT, CPT II, NDC).**

In order to help you maximize gap closures, ʻOhana pays $0.01 for certain CPT II codes to allow you to bill without receiving a non-payable code denial. Using CPT II codes for certain preventive care services and test results makes it easier for you to share data with ʻOhana quickly and efficiently.

HEDIS Bonus Amounts:

Measure	Amount
Cervical Cancer Screen	**$25**
Childhood Immunization Status (Combo 10)	**$50**
Diabetes HbA1c <8	**$30**
Diabetes HbA1c Test	**$20**
Well Child 15 Months Visits (6 or more visits)	**$50**
Well Child 3-6 Years Old Visit	**$50**
Well Child 12-21 Years Old Visit	**$30**

This announcement is subject to all of the terms and conditions of the Partnership for Quality Information Guide.

The program leverages your existing workflow as follows:

1. Schedule and conduct comprehensive patient exams.
2. Use the HEDIS® reports as guides to close care gaps.
3. Submit a claim/encounter containing all appropriate diagnostic and procedure codes and document in the patient's medical record.

Questions?

If you have questions about our P4Q Program, please contact your Provider Relations Representative, Quality Practice Advisor, or call Customer Service at **1-888-846-4262** (TTY **711**). The hours are Monday–Friday, from 7:45 a.m. to 4:30 p.m. HST

You can find more information in the Other Resources box after logging in at **https://provider.wellcare.com/ohanacare**.

Thank you for working with us to deliver quality healthcare to our members.

2021 Medicare Continuity of Care Bonus Program

(FORMERLY PARTNERSHIP FOR QUALITY)

Quality Addendum

Program Starts Jan. 2021 For Dates of Service Jan. 1, 2021 - Dec. 31, 2021

'Ohana Health Plans understands that the provider-member relationship is a key component in ensuring superior healthcare and the satisfaction of our members. Because 'Ohana recognizes these important partnerships, we are pleased to offer the 2021 Continuity of Care (CoC) Quality Bonus Program, which rewards PCPs for improving quality and closing gaps in care.

New in 2021, the CoC program includes an incentive enhancement to better align payment with quality.

Providers can now earn incentives at multiple levels based upon Star score achievement for each measure. We believe that our new incentive structure will better support you and your healthcare team in caring for our members.

Each measure will be calculated and rewarded individually. Star Rating is determined by comparing a CoC provider's compliance percentage for a given program measure to established benchmarks.

Program Measures	Base	3-STAR	4-STAR	5-STAR
Bone Mineral Density Testing	$10	$20	$30	$40
Care of Older Adult - Medication List and Review*	$5	$10	$20	$30
Care of Older Adult - Pain Screening*	$5	$10	$20	$30
Colorectal Cancer Screen	$10	$20	$30	$40
Diabetes - Dilated Eye Exam	$10	$20	$30	$40
Diabetes HbA1c ≤ 9	$10	$25	$40	$55
Diabetes Monitor Nephropathy	$5	$10	$20	$30
Hypertension	$5	$10	$20	$30
Mammogram	$10	$20	$30	$40
Medication Adherence – Blood Pressure Medications	$10	$25	$40	$55
Medication Adherence – Diabetes Medications	$10	$25	$40	$55
Medication Adherence – Statins	$10	$25	$40	$55
Medication Reconciliation Post-discharge	$10	$20	$30	$40
Statin Therapy for Patients with Cardiovascular Disease	$10	$20	$30	$40
Statin Use in Persons With Diabetes	$10	$20	$30	$40

**Dual Eligible Special Needs Plan (DSNP) members only*

2021 Medicare Continuity of Care Bonus Program Continued

Quality Bonus Instructions

1. The measurement period is Jan. 1 to Dec. 31, 2021. ‘Ohana must receive all claims/encounters by Jan. 31, 2022.
2. Schedule and conduct an exam with the eligible member using HEDIS® reports as guides to close care gaps and update diagnoses. Note: Additional Star measures may become applicable to eligible members as claims and data are received throughout 2021.
3. Provide appropriate medications to your members and encourage them to fill their prescriptions; consider 90-day supplies for members stable on therapy.
4. Upon completion of the examination, document care and diagnosis in the patient’s medical record and submit the claim/encounter containing all relevant ICD-10, CPT and/or CPT II codes by Jan. 31, 2022.

Payment Timeline

Payments will begin after processing claims/encounters for the first quarter of 2021. Payments will continue through 2022.

Additional Conditions

Only one Quality Bonus Payment will be made for a specific HEDIS and Medication Adherence member-measure combination.

Definitions

Eligible Member is a member who meets the age, sex, and/or disease-specific criteria, and the enrollment and other technical criteria, set forth in the HEDIS Technical Specifications or the most recent CMS Medicare Part C&D Star Rating Technical Notes document for the Program Measures.

CoC Provider means a primary care physician (PCP), vendor or independent practice association (IPA) who has a contract with WellCare and receives this Program Information Guide.

HEDIS means Healthcare Effectiveness Data and Information Set. HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

HEDIS Technical Specifications means the HEDIS 2021, Technical Specifications as published by the National Committee for Quality Assurance (NCQA) or any applicable successor specifications.

Medication Adherence Measures are the three Medication Adherence Measures published in the most recent CMS Medicare Part C&D Star Rating Technical Notes document:

- Medication Adherence – Diabetes Medications
- Medication Adherence – Blood Pressure Medications
- Medication Adherence – Statins

Program Measures are the HEDIS and Medication Adherence Measures that are included in the bonus amounts table. Program Measures are defined according to the HEDIS Technical Specifications or the most recent CMS Medicare Part C&D Star Rating Technical Notes document.

Important Contact Information

If you have questions about our CoC Program, please contact your ‘Ohana representative, or call Provider Services at **1-866-319-3554** (TTY **711**). You can reach us Monday–Friday from 8 a.m. to 8 p.m.

Help Patients Monitor Cholesterol to Lower Heart Disease Risk

Patients with obesity, high blood pressure and high cholesterol are at an increased risk for heart disease and stroke. Because elevated cholesterol and blood pressure often have no warning signs, patients must take proactive steps to improve their health and well-being.

Patients will ask, "How can I monitor my cholesterol, blood pressure and weight?" It is very important for physicians to provide ways to reduce cholesterol, BP and weight to lower their heart disease risk.

Make a Diet Change

One way to lower cholesterol and blood pressure is for patients to eat a heart healthy diet that is low in added sugars, sodium, and saturated and trans-fat. A healthy diet will also include a variety of fruits, vegetables, whole grains, low-fat dairy products, poultry, fish, legumes, nontropical vegetable oils and nuts.

Patients should try to eat oily fish, such as salmon, twice a week, while limiting red meats. If a patient chooses to eat red meats, advise them to select lean cuts of meat. It is also important for patients to trim any visible fat. When eating poultry, patients should remove the skin before eating.

For additional information on how to help patients with dietary improvements, visit "Nutrition Science for Health and Longevity: What Every Physician Needs to Know," which can help you begin an effective nutrition conversation with patients. The four-hour, self-paced course is developed and hosted by the Gaples Institute for Integrative Cardiology, a nonprofit focused on enhancing the role of nutrition and lifestyle in health care, and distributed in collaboration with the AMA Ed Hub™.

The AMA Ed Hub is an online platform that consolidates all the high-quality CME, maintenance of certification, and educational content you need—in one place—with activities relevant to you, automated credit tracking and reporting for some states and specialty boards.

Get Active

When patients live sedentary lifestyles, it can lower their high-density lipoprotein (HDL), sometimes called "good cholesterol." To improve HDL and reduce low-density lipoproteins, encourage patients to increase the amount of physical activity they are getting each day.

Performing 150 minutes of moderate-intensity aerobic exercise a week is enough to lower both cholesterol and high blood pressure. Encourage patients to go on a brisk walk, swim, ride a bicycle or even attend a dance class. These activities are easy to accomplish and may significantly improve their health.

Lose Weight

Making key lifestyle changes can help patients lose 3–5% of their body weight, which can result in meaningful health benefits. Larger weight losses of about 5–10% can produce even greater benefits for patients.

To help patients lose weight, it is important to consume fewer calories than used through normal metabolism and physical activity each day. Patients should reduce the number of calories they eat,

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Help Patients Monitor Cholesterol to Lower Heart Disease Risk Continued

while increasing physical activity. However, to maintain weight lost or to minimize the amount regained, some people might need to increase the amount of physical activity performed each week to about 200 or 300 minutes.

Quit Smoking

HDL cholesterol is lowered when a person smokes. But what is worse is when a person with unhealthy cholesterol levels also smokes, their risk of coronary heart disease significantly increases. Smoking also compounds the risk presented by other risk factors for heart disease, such as high blood pressure and diabetes.

By quitting, patients can improve their cholesterol levels and help protect their arteries. For patients who do not smoke, it is also important that they avoid exposure to secondhand smoke.

Take medications as prescribed

For some patients, lifestyle changes may prevent or treat unhealthy cholesterol levels. However, for those with high cholesterol, medication may also be needed. Work with your patients to develop a treatment plan that meets their individual needs.

If medication is required, be sure your patients understand the importance of taking their medications correctly. The benefit to your patient's health is worth making medications part of their normal routine to lower cholesterol and prevent heart disease.

The AMA has developed online tools and resources created using the latest evidence-based information to support physicians to help manage their patients' high BP. These resources are available to all physicians and health systems as part of Target: BP™, a national initiative co-led by the AMA and American Heart Association.

Annual CAHPS® Survey – What Matters Most to Your Patients

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is an annual survey mailed to an anonymous select sample of our health plan members. The purpose is to assess member experience with their providers and health plan to improve the quality of care provided. This survey focuses on asking your patients whether or how often they experienced critical aspects of health care, including communication with their doctors, understanding how to take their medications, and the coordination of their healthcare needs. **We hope you will encourage your patients to participate if selected.**

The pharmacy team can affect the member experience, whether we interact with members directly or not, by ensuring that we address the following items that are addressed in the annual CAHPS survey:

- ✓ Assist members in understanding and accessing their pharmacy benefits (i.e. what medications are/are not covered),
- ✓ Identify (and mitigate) barriers to members obtaining and taking their medications.
- ✓ Ensuring appropriate communications with providers and health plans occur to complete the processing of timely authorizations

These factors are important for our members (your patients) to take their medications on time but also to ensure adherence of their medication regimen(s).

We value and appreciate the excellent care you provide to our members and look forward to partnering with you.

Source: Centers for Medicare & Medicaid Services. Consumer Assessment of Healthcare Providers & Systems (CAHPS). https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS

How to Improve Patient Satisfaction and CAHPS Scores, Part 1 of 3

WHAT IS THE CAHPS?

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

Know What You Are Being Rated On	What This Means:	Tips to Increase Patient Satisfaction:
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 an understandable way • 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 • Decision making tools and quick reference guide are available at: **www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/tools/index.html** • Ask your patients, *"What should I know about you that may not be on your medical chart?"*

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How to Improve Patient Satisfaction and CAHPS Scores, Part 1 of 3 Continued

Know What You Are Being Rated On	What This Means:	Tips to Increase Patient Satisfaction:
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.

Knowledge is Power.

Make sure both you and your medical team know the questions your practice is being rated on. For more information and research on ways to improve patient satisfaction, see *"Flipping Health Care: From 'What's the Matter' to 'What Matters to You?'"* You can access the article and video at the websites below.

Sources and References:

www.ihi.org/Topics/WhatMatters/Pages/default.aspx Christina Gunther-Murphy-What Matters Office Practice Setting IHI

www.ihi.org/resources/Pages/AudioandVideo/WIHIWhatMatters.aspx

2016 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

‘Ohana’s Provider Portal Has New Live-Chat Offerings

CHECK OUT ALL THE NEW WAYS PROVIDERS CAN EASILY ACCESS IMMEDIATE ASSISTANCE

Providers will now have more options to easily access help thanks to the new Chat offers that are now available on the Provider Portal!

Live-Chat agents are trained to quickly – and accurately – answer your questions.

New Live-Chat Offers on the Provider Portal:

Provider Home Page

Claim Main Page

Care Management Home Page (Authorizations)

Claims Appeals & Disputes Page

If you would like more information on Live-Chat on the Provider Portal, please contact your provider representative.

‘Ohana New Benefits 2021

PLEASE BE ADVISED THAT EFFECTIVE JULY 1, 2021 ‘OHANA HEALTH PLAN WILL BE OFFERING THE BELOW BENEFITS

However, not all benefits will be ready on July 1st. Benefits that will not be ready for a July 1st go-live date have been noted below in bold, with their anticipated go-live date.

Asthma Program

- **Hypoallergenic Bedding** - Eligible members with asthma can get hypoallergenic bedding Mattress casings and Pillow casings).
- **Carpet Cleaning** - Covers the cost of 2 carpet cleanings per calendar year, for qualified members with a diagnosis of asthma
- **HEPA Filter Vacuum Cleaner** - Provides a HEPA vacuum cleaner at no cost to qualified members with a diagnosis of asthma.
- **Allergy Mask** – Provides an allergy mask to protect against air pollution

Pain Management Program (Go live 10/1 or later)

This program is to help qualified members manage chronic pain; and alternative to opioids. Prior authorization is required by a Health Coordinator or a referral from a PCP or treating physician, limitations apply.

- **Chiropractic** - For manipulation of the spine by a licensed chiropractor to treat, pain. Limitations apply
- **Acupuncture** - For pain management. For stimulating certain points on the body, most often with a needle penetrating the skin, to alleviate pain or to help treat various health conditions. Limitations apply
- **Massage Therapy** - Manual manipulation of soft body tissues (muscle, connective tissue, tendons and ligaments) to help manage pain. Limitations apply

Traditional Healer

This benefit covers all traditional healing (Native American and Spanish/Mexican healers). Members will receive up to $250.00 per calendar year **(this benefit is reimbursement only).**

Ambulatory Blood Pressure Monitoring

This benefit is for qualify members at-risk with hypertension can receive a blood pressure cuff to self-monitor

Cell Phone ConnectionsPlus Program

‘Ohana will provide eligible members with free smart phones and data through our ConnectionsPlus Program.

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‘Ohana New Benefits 2021 Continued

Caregiver Package

Provides package to caregivers with phone numbers, keepsake bag, caregiver educational materials, caregiver journal, and information regarding support groups.

Social Call Program (Go live 10/1 or sooner)

This program links local community-based volunteers to qualify members that are able to facilitate ongoing calls with those who would like more social contact, creating meaningful connections.

Weight Watchers

‘Ohana offers a 6 -month membership benefit to qualify members. The program’s goal is to support healthy lifestyles and improve health outcomes.

Community Care Services (CCS)

Cell Phone ConnectionsPlus Program

‘Ohana will provide eligible members with free smart phones and data through our ConnectionsPlus Program.

Transportation

Covers transportation to the pharmacy. When they are unable to access needed medications due to transportation and no viable alternative is available.

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:

'Ohana Health Plan
ATTN: Provider Operations
949 Kamokila Blvd., Suite 350
Kapolei, HI 96707

Fax:

1-866-788-9910

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.

Medicare:

Updates have been made to the Medicare Formulary. Find the most up-to-date complete formulary at **https://www.wellcare.com/Hawaii/Providers/Medicare/Pharmacy.**You can also refer to the Provider Manual available at **www.ohanahealthplan.com/Hawaii/Providers/Medicare**, hover over *Provider* drop down and click *Overview* under Medicare icon. You can also view more information on 'Ohana's pharmacy UM policies and 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.

Electronic Funds Transfer (EFT) Through PaySpan®

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.

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.

MEDICARE ONLY

Point of Care Formulary Information for Providers

PRESCRIBE WITH CONFIDENCE – EVERY DRUG. EVERY PLAN. EVERY TIME.

Are you and your team spending valuable time processing prior authorizations?

We have expanded our relationship with MMIT to deliver comprehensive drug coverage information directly to your desktop and mobile devices. In addition to 'Ohana's extensive support resources, providers can identify plan-specific drug coverage and restriction criteria as well as alternative therapies with these medical applications.

Epocrates®, an athenahealth service, is the #1 point of care medical app among U.S. physicians. It is trusted by over 1 million healthcare professionals. Just download the free app or search from your desktop with epocrates® web at **www.epocrates.com**.

MMIT's Coverage Search is a top-rated drug coverage search application. Download the free app or search from your desktop at **www.FormularyLookup.com**.

Quickly obtain the details you need to select the best therapeutic option, eliminate denials and reduce administrative drain on you and your team with epocrates® and Coverage Search.

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.

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/Hawaii/Providers**.

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/Hawaii/Providers**, 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/Hawaii/Providers**, click on *Tools*.

We're Just a Phone Call or Click Away

Medicare:
1-888-505-1201

Medicaid:
1-888-846-4262

www.ohanahealthplan.com