providerNEWS

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

WINTER **2023**

DEPRESSION AND THE HOLIDAYS

Appeals for Plan Directed Care

Credentialing Corner

Carelon Behavioral Health Resources Available

AND **much more!**

Printed and mailed 12/15/2023

Welcome Home: Member Engagement with the Patient-Centered Medical Home

For Primary Care Physicians (PCPs), the Patient-Centered Medical Home (PCMH) represents a philosophy of providing coordinated, comprehensive care that is patient-centric and team-based. As the American College of Physicians notes, the PCMH "is a care delivery model whereby patient treatment is coordinated through their primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand." The Plan embraces this philosophy.

The PCMH philosophy means our members will receive safe, quality care, including services and treatment plans which address their unique health concerns and goals. The PCMH includes medication reconciliation, coaching and education to help members meet these goals.

Additional benefits of the Medical Home model include:

- a reduction in emergency department visits;
- decreased delays in members seeking treatment;
- closer management of chronic diseases;
- improved communication with patients regarding their role in the plan of care.

It is important that members understand how to directly communicate with the PCP's office. They sometimes ask the Plan to intercede with the PCP on their behalf, which causes fragmentation and delays in care. Members should have a copy of the plan of care and know who to call with questions. To maximize the effectiveness of the Medical Home, the PCP office should inform members from the outset of expectations on both sides.

- **Medication review helps members understand the medications they are taking and how they are affected by taking or not taking them.**
- **A personalized plan of care allows for mutual goal setting and evaluation of progress to goals by the provider and the member.**
- **Coaching and education focus on the information members need to manage their unique health care needs. Team support such as community resources, Plan social work or case management staff, and family support systems can provide the added connection needed to help members continue to strive to meet their health care goals.**

Providers can contact the Case and Disease Management department to refer members for assistance. Qualified staff members are available to support members who need extra coaching and support related to their chronic condition or current treatment plan. Referrals can be sent to the department via fax at 1-888-314-0794 or by calling 1-888-211-9913.

Depression and the Holidays

The winter holidays are upon us. While the holidays can be a joyous time, for some it can be a time of experiencing intense feelings of depression. This time of year often elicits stress, and financial pressures. For some people the holidays highlight losses that can bring forth feelings of grief, loneliness, and emptiness.

Your patients may be struggling with depression, sadness, and thoughts of suicide. Many patients regard their Primary Care Physicians (PCPs) as trusted friends and confidants, with whom they can discuss their feelings. While not all patients are openly forthcoming about how they are feeling, many are willing to share if asked. Please take time to ask your patients how they're doing emotionally.

The Health Plan also has Nurse Case Managers and Social Workers who can offer a friendly voice and listening ear to your patients. They can help connect folks with behavioral health services, community services and support groups. We encourage you, as the PCP, to reach out to the Plan so we can get in touch with your neediest patients. If you have a member that you feel could benefit from speaking with a Registered Nurse or Social Worker, please complete the Case/Disease Management Referral Form found in your provider manual or on the Plan website under the 'Tools and Resources' page.

Patients may also self-refer via the Member Portal or by calling the Member Services number on the back of the Plan ID card and asking for Case Management or Social Services.

Please consider posting in your office the 988 Suicide & Crisis Lifeline. The 988 Suicide & Crisis Lifeline is staffed 24 hours a day, every day and provides free and confidential support that is available by simply dialing 988. Sometimes just one conversation can change a life.

PARTNER WITH CASE AND DISEASE MANAGEMENT

NURSES

The Plan's Case and Disease Managers and Social Workers can collaborate with you to help provide each member the services they need to better manage their health or plan of care. Physicians and providers can refer a patient to one of our programs with just a phone call or written referral. Our overall goal is to support the member's success in implementing his or her plan of care. The referral form can be found on the Plan's website or in your Provider Manual.

Disease Case Managers can offer education and coaching programs for members based on chronic conditions such as Diabetes and Cardiovascular Disease. These programs are built around national evidence-based guidelines. The focus is on preventing complications and/or exacerbations, enhancing self-management and reducing acute episodes.

Complex Case Managers can assist members with urgent or acute events and coordination of services. The goal is to enhance coping and problem-solving capabilities, assist in appropriate self-direction, support proper and timely needed services and reduce readmissions.

Social services support is integrated into our Case and Disease Management program. Our Social Workers work in conjunction with our Nurses in identifying health and community resources which might benefit the member.

The Plan also has a full-time Registered Dietitian on staff that can help members to determine an appropriate diet based on their disease or condition. This is a service that is available to all Plan members at no additional cost. Physicians can refer a member to the Registered Dietitian, or a member can self-refer.

Members enrolled in Case or Disease Management and their physicians receive ongoing support from Nurses on staff. Members may choose not to participate in the program at any time and it does not affect their benefits.

Many times, Nurses, Social Workers, or the Dietitian will need to engage the PCP to resolve member concerns or issues. We appreciate providers supporting Member participation in these programs as a collaborative effort to maximize health and wellbeing. Provider communication efforts are also enhanced via care plan developed by

the Nurse, Social Worker, or Registered Dietitian along with the member, which they send to the PCP, highlighting mutually agreed upon goals and interventions. They provide updates to the care plan when initiatives change.
Our CMDM staff also remind members who see Behavioral Health providers to fill out a Release of Information form, giving those providers permission to share information with the PCP. You can facilitate this process by providing members with a copy of the form, which is in the Carelon Behavioral Health provider toolkit **(https://www.carelonbehavioralhealth.com/providers/resources/provider-toolkit).**

Thank you for all you do to help keep the channels of communication open and to provide the best care for our members!

CONTACT

Call us toll-free at 1-888-211-9913
from 8:00 a.m. to 4:00 p.m. EST.
Monday through Friday.

To access the referral form on the internet visit the Plan website and follow this path: **Providers -> Tools and Resources -> Case/Disease Management Referral Form**

ENHANCING PATIENT-DOCTOR COMMUNICATION

One of the essential factors in achieving patient-centered care is good physician-patient communication, this is one element that should not be overlooked. There are many suggestions such as maintaining eye contact as well as talking slowly, clearly and less often. You can also use the Teach-Back and Ask Me 3 Methods. The Teach-Back method is when you ask the patient to explain in their own words the information you gave them. This method demonstrates understanding and comprehension of the information the patient received. It also lets the patient take an active role in their care and lets the physician assess health literacy and understanding which ultimately helps improve health outcomes.

The Ask Me 3 Method encourages patients to ask 3 questions:

1.) What is my main problem?
2.) What do I need to do?
3.) Why is it important for me to do this?

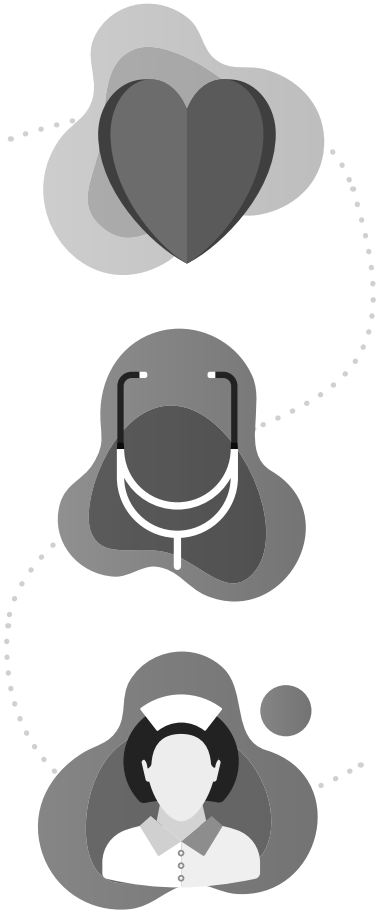
While it may not be customary, you can improve patient-physician communication by sharing your patient's medical notes with them. When patients can read their medical notes, it fosters patient engagement. Ultimately, when patients are more actively involved in their care, it enhances their care experiences, builds trust between the physician and patient, and improves their satisfaction.

Also, if a patient can read what is on the chart, he or she will have the opportunity to correct any mistakes or add other helpful details, thereby preventing medical errors. Notes-sharing also counts towards the Meaningful Use Stage 1 requirement of providing patients with an electronic copy of their health information, and the Stage 2 requirement of providing clinical summaries for patients for each office visit.

While there are many platforms for sharing notes with patients, such as the OpenNotes project, physicians don't need to implement a formal electronic program to join this movement towards transparency and patient engagement. Physicians can start engaging their patients today just by letting them look at their records during their regular appointments. It's a simple gesture with surprisingly beneficial results.

Chronic Care Improvement Program:
Reducing Readmissions for Members with CHF

Medicare Advantage (MA) organizations are required to conduct a Chronic Care Improvement Program (CCIP) initiative every three years. Our Health Plan's CCIP is focusing on promoting effective management of members that have incurred an inpatient readmission where Congestive Heart Failure (CHF) was listed as a primary or secondary diagnosis.



Members are identified for inclusion into our CCIP based on medical claims. The target population is Medicare members (individuals aged 65 or older or disabled) with a readmission having occurred within the past two years. The CCIP will be carried out over a three-year period.

CHF affects nearly 5 million Americans and is responsible for more hospitalizations than all forms of cancer combined. The disease is responsible for 11 million physician visits each year and contributes to approximately 287,000 deaths annually.

The intent of this CCIP is to reduce the likelihood of a readmission into an acute care inpatient facility. Inclusion in this CCIP is open to all members, although the targeted group will be those with a history of a CHF related admission and readmission over the past two years. Members involved in the CCIP will have access to nurses that can provide Disease Management services at no additional cost. Members will also be offered a consult with the Plan's Nutritionist to review their diet and help make appropriate food selections.

As part of the Plan's Disease Management model, nursing staff provide ongoing self-management education and support to the member and help to coordinate medical and social service needs. The goal is to keep members healthy, happy, and out of the hospital.

CCIP progress will be measured by advancement toward a target goal approved through the Plan's Quality Program up to and including the Board of Directors. The goal is derived from review of the prior admissions and readmissions where a diagnosis of CHF was included.

If you have a member that you feel could benefit from participation in this program, please complete the Case/ Disease Management Referral Form found in your provider manual or on the Plan website under the 'Tools and Resources' page.

A Reminder ABOUT
Medical Record Standards

All of Our Members Benefit from the Safeguards Established by Federal and State Guidelines

The Plan strives to provide the best quality of care to its members and expects all providers who service our members to adhere to stringent Federal and State standards regarding documentation, confidentiality, maintenance and release of medical records, as well as personal health information (PHI).

The Plan's Provider Manual describes the medical record standards required for contracted providers. As a reminder, ALL providers must follow these standards and cooperate with the Plan in activities related to quality assurance monitoring of medical records. Meeting these requirements applies to both electronic and paper medical record.

Appeals for Plan Directed Care

What is Plan Directed Care? CMS considers care to be Plan Directed, when a contracted provider or an agent of the Plan, refers the member to a non-contacted provider for care or services. Section 160 of the Medicare Managed Care Manual, Chapter 4 – Benefits and Beneficiary Protections, states: "MA organizations have a responsibility to ensure that contracting physicians and providers know whether specific items and services are covered in the MA plan in which their patients are enrolled.

If a network physician furnishes a service or directs an MA beneficiary to another provider to receive a plan-covered service without following the plan's internal procedures (such as obtaining the appropriate plan pre-authorization), then the beneficiary should not be penalized to the extent the physician did not follow plan rules."

What are some examples of Plan Directed Care?

- PCP refers the member to a non-contracted Cardiologist for treatment
- Contracted specialist ordered genetic lab tests with a non-contracted lab provider
- Contracted surgeon schedules surgery at a non-contracted facility

Why does this matter? There are no protections in place for members when they are seen by a non-contracted provider. The non-contracted provider is not bound by a contract with the Plan and can balance bill the member. It puts the member at risk for delays in care when services are elusive for proper care. It puts providers at risk for potentially not following the appeal process as a measure of additional administrative work for payments. Additionally, it puts the plan at risk during the appeals and grievance processes that occur because of denial of payments and services. Freedom and Optimum has performed their own analysis of appeals overturned and one category stood out amongst the rest. The results showed that appeals for payments submitted by non-participating providers were being overturned as a direct result of par providers referring to non-participating providers through plan directed managed care.

What can be done to alleviate this? Being a provider, as the face of Freedom and Optimum, you can prevent delay of care for a member and decrease the rate of nonpayment for services rendered by referring in network or obtaining a prior authorization on behalf of the member. These small actions have a direct impact on patient care and prevent wasted time for the member, but also the additional administrative work invested into referring to providers out of network. Additionally, it allows the plan to direct payments to providers who choose to participate in our network and participating providers to indirectly improve member health outcomes. If there is a need to refer a member to a non-contracted provider, we count on our contracted providers to follow the Plan's prior authorization process. This can ensure successful outcomes for the members, prevent non-medically necessary care, and protect the members from potential balance billing.

CREDENTIALING CORNER

The plan accepts CAQH Proview Credentialing applications.

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

When logging into the CAQH Provider Data Portal to update or re-attest to your information, please review the informational banners used by CAQH to announce system updates and be sure to review the monthly updates CAQH sends out via email. **Please be sure all documents uploaded to CAQH indicate "Pass" and are legible including the Attestation Form.**

Also, please continue to keep your credentialing application and attached documentation current in the CAQH ProView database including the "Release and Attestation" form.

The following items are of much importance in the credentialing process:

- **State Medical License(s) please include expiration dates**
- **DEA Certificate or protocol if you no longer hold a DEA and reason for non-renewal if you chose not to renew your certificate**
- **Valid Insurance Information**
- **Practice locations**
- **Hospital Admitting privileges OR if you are a PCP and you do not have hospital admitting privileges please ensure the Hospital Admitting Arrangements Supplemental Form is fully completed**
- **Partners/Covering Colleagues**
- **Questionnaire responses and explanations as required.**

Thank you for your timely submission!

……..one more reminder, please promptly notify us of any changes to your credentials.

For Providers Not Part of CAQH Proview:

The notification cover letter specifies the steps along with the Plan application which needs to be completed and returned; and a list of documents needed for re-credentialing as well as the deadline for the submission. **Maintaining Active provider status is dependent upon completion of the re-credentialing process prior to the expiration date.**

CARE COORDINATION between

Medical and Behavioral Healthcare Providers

Undeniably, communicating with patients is essential to establishing lasting relationships with them and enhancing quality of care. At the same time, patients often have multiple specialty providers; as the PCP, you are overseeing and communicating with these specialists and they with you. This is vital for excellent care.

When providers exchange information about a patient, it can flesh out the treatment plan and decrease the chance of medical errors, complications, duplicate diagnostic testing and unnecessary emergency room visits. It can give providers a more expansive view of the patient to enable effective interventions. This is especially true if the patient is seeing a behavioral health provider, whether a psychiatrist, a psychologist, or a counselor.

We strongly encourage you, as the head of the Medical Home, to request your patients – our members – to ask their behavioral health providers to share records with you. In order to do this, each patient who sees a behavioral health provider would need to complete a Release of Information Form and present it to that provider. As information is exchanged, you can document it in the medical record.

One of Freedom/Optimum's ongoing Quality initiatives targets information-sharing between a member's Behavioral Health provider and the PCP. We conduct retrospective reviews each year of PCP office notes from the previous year, looking for corroboration of the PCP's awareness of and collaboration with the Behavioral Health provider. Shared information is essential to good care; thank you for encouraging information exchange in the interests of helping patients attain and maintain optimal health.

Your Role in Care Transition Support

Do you know when one of your patients is admitted to a hospital?

Our Health Plan is making a renewed effort to identify gaps in treatment and proactively resolve issues for members after a hospital stay. The goal is to remove barriers that prevent the member's plan of treatment from being implemented, while positively affecting readmission rates.

Did you know the Health Plan's staff makes Discharge Support calls to members shortly after their discharge?

Discharge support calls help us identify members who may be at risk for readmission. Our experienced staff is assessing:

- Whether discharge instructions are available and understood;
- If the member's current support mechanisms are adequate, including psychosocial barrier resolution;
- Medication compliance, e.g., prescriptions being filled and taken as prescribed; and/or
- Whether home health visits or Durable Medical Equipment have been scheduled or provided, when applicable.

How soon do you see a patient after their discharge from an acute care facility?

Members are encouraged to bring all discharge instructions to their follow-up PCP visit. If the member has not scheduled a follow-up appointment at the time of the Discharge Support call, the Health Plan staff facilitates the appointment scheduling with the PCP's office staff. The target is for the member to have a *follow-up PCP consult within seven days* post-hospitalization.

Do you have a copy of the Discharge Summary?

With the growing use of hospitalists, the discharge summary serves as a communication tool and provides the basis for continuing care especially if you don't have access to all of the member's inpatient documentation. Both CMS and Hospital accreditors require a discharge summary documenting the patient's outcome of hospitalization, disposition and provisions for follow-up care. The Discharge Summary provides valuable information regarding the member's inpatient stay, treatment and medications. Providers are encouraged to actively seek this information to provide appropriate follow-up care and prevent readmission.

Effective, patient-centered healthcare depends on information-sharing between providers, including Behavioral Health providers. We conduct retrospective reviews each year of PCP office notes from the previous year, looking for corroboration of the PCP's awareness of and collaboration with Behavioral Health providers. If the member needs Behavioral Health follow-up, we encourage you to facilitate communication by providing the member with a Release of Information (R.O.I.) form to fill out and give to the Behavioral Health provider. That provider can then share insights and updates with you. You may find the form at **https://www.carelonbehavioralhealth.com/providers/resources/provider-toolkit/coordination-of-care.**

HEDIS Measures After Discharge

Following up with the provider timely after an inpatient stay, ED visit, Substance Abuse Disorder, or Mental Health Illness hospitalization is an important focus of the Plan. We expect members to follow up timely with their provider to ensure that all parties are aware of any medical changes that may have occurred. Timely follow-up is also an important aspect of many HEDIS measures.

It is important to know that there are five HEDIS measures that specifically have a 7-day follow up requirement. The measures are listed below for your review. Take time to review each measure as there are different criteria based on the specific population. Keeping up to date with HEDIS measures can help ensure quality healthcare is regularly provided.

1. Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions **(FMC)**
    - The percentage of emergency department (ED) visits for members 18 years of age and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.

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

3. Follow-Up After Emergency Department Visit for Mental Illness **(FUM)**
    - The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness.

4. Follow-Up After High-Intensity Care for Substance Use Disorder **(FUI)**
    - The percentage of acute inpatient hospitalizations, residential treatment or withdrawal management visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder.

5. Follow-Up After Emergency Department Visit for Substance Use **(FUA)**
    - The percentage of emergency department (ED) visits among members aged 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up.

We hope that this information will help you plan scheduling member follow-up.

Carelon Behavioral Health Resources Available

Primary Care Providers (PCPs) are on the front line when it comes to identifying and treating Behavioral Health (BH) issues. It is estimated that 60 percent of BH issues seen in primary care are related to depressive disorders and half of patients seen have psychiatric symptoms.

Behavioral Health Services

As the plan's provider, Carelon Behavioral Health (Carelon) does not provide direct care. As a managed behavioral health care organization, Carelon manages a network of:

- Psychiatrists
- Doctorate prepared licensed psychologists
- Master's prepared licensed clinicians
- Day treatment programs
- Inpatient Treatment Programs
- Residential Programs
- Partial Hospitalization Programs

PCP Toolkit

Delivering behavioral health services in primary care settings reduces stigma and discrimination. Carelon offers PCPs a toolkit to help with the identification and next steps in the treatment of behavioral health conditions. Carelon continues to be committed in supporting the integration of medical and BH services with the goal of improved outcomes. The PCP toolkit offers screening and evaluation tools for ADHD, anxiety, depression, postpartum, depression, substance use and more. Resources can be found here: **Provider Toolkit | Carelon Behavioral Health**

Telehealth Services Available

Telehealth has become an additional modality for providing care to members. Telehealth allows the member to receive much needed behavioral services in a safe and secure environment. Benefits of telehealth include:

- Improve member quality outcomes
- Reduce hospitalization readmissions
- Increase member engagement
- Ability to expand access to care and services
- Ability to offer extended hours

Carelon offers telehealth guidelines and resources found on Carelon's website at **Telehealth | Carelon Behavioral Health.** If you have a member, you would like to refer to our Care Management Program, please call the National Provider Service Line at **1-800-397-1630** to make a referral. Our clinicians will review the request and follow up with the member as appropriate.

Communicating With The PCP

Each network psychiatrist and psychotherapist is required to seek consent to release confidential information from the member. They must obtain the patient's or authorized legal representative's signed and dated consent before communicating with the patient's PCP regarding their behavioral health treatment. Encourage your patient to sign a release located in the Carelon provider toolkit.

Carelon Case Management

Carelon offers members with mild to complex or high risk behavioral health conditions the enhanced service of Case Management (CM). Case management supports the coordination of care and services to members who need help navigating the health care system.

Referring to Carelon Behavioral Health

You may determine that a member can benefit from the coordination of services that Carelon's case management can provide. It can be as easy as helping a member get the appropriate referral to a BH service or cases that are more complex. Potential situations where a referral to Carelon CM can help:

- A member has symptoms of clinical depression and follow-up is indicated for BH services or help knowing what services are available
- A member could benefit from therapy to deal with acute or ongoing stressors
- A member requires evaluation for an acute, non-life-threatening crisis
- A member is diagnosed with a severe and persistent mental illness (SMI) which requires ongoing monitoring and treatment
- The member shows signs or symptoms of an eating disorder
- The member requests an evaluation for substance use

To make a referral to a Carelon licensed behavioral health clinician please call **800-397-1630 or email: BH_cm@carelon.com.**

Other provider resources for behavioral services can be found on Carelon's website at **Provider Toolkit | Carelon Behavioral Health**

2024 Policy and Technical Changes to the Medicare Advantage Program

Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program - Enrollee Notification Requirements for Medicare Advantage (MA) Provider Contract Terminations (§§ 422.111 and 422.2267)

New CMS requirements regarding changes to provider network, including terminations of a contracted provider and enrollee notifications:

45-DAY NOTICE OF PROVIDER TERMINATION

CMS requires notification to Plan enrollees when a provider network participation contract terminates. A component of these new requirements (Final Rule) would be for Health Plans to notify, at least 45 days in advance, all current enrollees who have ever been patients of the primary care leaving their plan's network. Thus, giving enrollees more notice (and therefore more time) to decide how to proceed with any active course of treatment.

3-YEAR LOOKBACK PERIOD

In addition to notifying enrollees who are currently assigned to the terminating primary care provider, Health Plans would also now be required to notify enrollees who have been patients of the terminating primary care in the past three years.

These two new requirements applies both to contracted Primary Care Physicians and Behavioral Health providers (Although BH provider terminations are not processed in house).

Reach out to your Provider Relations Representative if you have any questions regarding these new requirements and how it will impact your office, your patients and/or your group.

Beta Blockers

If your patient was recently diagnosed with a heart condition like heart failure or an irregular heart rhythm or was in the hospital for a cardiac related event, you may have prescribed a beta blocker. For many people the addition of a new medication can be an upsetting event. Your patient may be afraid to ask questions about the medication and why it is being prescribed. They may have concerns about the affordability of the medication.

It is important to acknowledge that not all patients have the capacity to understand the benefits of beta blocker therapy. They may be turned off by the possible side effects and choose to not take the medication. Providing additional education as to why they need the medication may be helpful in increasing compliance.

Since side effects associated with beta blockers may lead to patient non-compliance, you may not discover this until the follow-up visit. Providing your patient with a drug that is well-tolerated can lead to increased compliance and improved outcomes.

The cost of the medication is also a factor to take into consideration. Many patients live on fixed incomes and may have trouble affording a brand name medication. Propranolol ER, Propranolol, Metoprolol/Hydrochlorothiazide, Metoprolol Succinate, Metoprolol Tartrate, Metoprolol, Carvedilol ER, Carvedilol, and Atenolol are all available as a TIER I medication at no cost to the patient. The Health Plan also has Social Workers available that may be able to help your patient identify co-pay assistance programs. If the patient qualifies for the program(s) then they may be able to receive assistance in meeting the co-pay. If you have a member that you feel could benefit from participation in this program, please complete the Case/Disease Management Referral Form found in your provider manual or on the Plan website under the 'Tools and Resources' page.

Stress-Free Medication Delivery for Your Patients

Medications can work wonders to improve your patients' health, especially for long-term conditions such as high blood pressure, diabetes, heart disease or asthma. But keeping track of and picking up medications can be burdensome for chronically ill patients.

CarelonRx mail-order pharmacy, included in Freedom Health's and Optimum Healthcare's pharmacy benefit, can simplify the ordering and delivery of prescription drugs. Your patients can get 90-day orders (up to 100 day orders for tier one drugs) delivered to their homes with free standard shipping; the 90-day option may even cost less than 30-day supplies.

There are 3 different ways patients can start Home Delivery through CarelonRx:

1. Sign up online at **www.carelonrx.com.** Log in to or register for an account and select "Request a New Home Delivery Prescription."

2. Call Pharmacy Member Services at the number on the back of their Plan I.D. card.

3. Providers will need to fax or electronically send new prescriptions to CarelonRx Pharmacy to ensure a smooth transition to home delivery.

More specifics to know about CarelonRx's mail-order pharmacy benefit:

- First-time orders take about 5 days to process.
- Refills take 2 days to process and patients can set up automatic refills, as long as the prescription is valid.
- Shipping times can vary, but orders generally arrive within 3 to 5 days through standard (free) shipping, or 2 to 3 days through expedited shipping for a fee.

CarelonRx's home medication ordering and delivery process helps make patients' lives a little easier!

Testing for Hemoglobin A1c

The Health Plan has Registered Nurses and a Dietitian available to help members manage their diabetes. The nurses work with the members to educate them on a proper diet, ideas for exercise, lab values, and tips on how to live a healthy lifestyle. The nurses can also refer a member to our dietitian for additional information on diet such as portion sizes, carbohydrate counting, and what foods to avoid. This information is free to any member of the Plan.

As discussed, the nurse will review available lab values with the member and having a current Hemoglobin A1C is a good place to start. The Plan asks that you consider informing your patients that a Hemoglobin A1c is a simple blood test that can provide an estimate of their average blood sugar over the past three months.

Please consider ordering a Hemoglobin A1c as part of a routine work-up for any patient at risk of, or currently managing, diabetes. Encouraging patients to use the Plan's approved vendor, LabCorp, will ensure that the results get communicated without any additional effort.

If you have a member that you feel could benefit from speaking with a Registered Nurse or a Dietitian, please complete the Case/Disease Management Referral Form found in your provider manual or on the Plan website under the 'Tools and Resources' page.

Behavioral Health Care Tools to Assist in Sharing Information

We routinely collaborate with Carelon Behavioral Health, our Health Plan's Behavioral Health vendor, to identify, facilitate and assess continuity & coordination between medical care and behavioral healthcare providers. Through that collaboration, we wanted to share the following resources that provide details and release of information tools that may help you in facilitating the exchange of information with our members:

- Behavioral Health Provider Handbook and
- Web based PCP Toolkit

The Carelon Behavioral Health Provider Handbook is posted on Carelon's website, https://www.carelonbehavioralhealth.com/providers/resources/provider-handbook and the PCP Toolkit can be accessed through https://www.carelonbehavioralhealth. com/providers/resources/provider-toolkit. Along with Carelon Behavioral Health, we strongly encourage Primary Care Physicians, Specialists and behavioral health providers to share relevant information regarding diagnoses, medication, and/or treatment to help improve health outcomes and continuously deliver quality care to our members. You can help facilitate this sharing of information by asking our members who see a Carelon provider to fill out a Release of Information form (available in the PCP Toolkit) to give to that provider, allowing the sharing of updates with you.

PROVIDER RELATIONS DEPARTMENT 2023

Administration

Title	Name	Office Number	Ext	E-mail
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FREEDOM HEALTH

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