providerNEWS

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

SUMMER **2023**

2023 MTM PROGRAM INFORMATION

All About Member Care Plans

Don't Forget the Statins!

Partner with Case and Disease Management Nurses

AND **much more!**

Printed and mailed 6/16/2023

The plan accepts CAQH Proview Credentialing applications.

Please continue to keep your credentialing application information and attached documentation current in the CAQH Proview database. When logging into your ProView Provider System, please take note of the informational banners that CAQH uses to announce updates to their system, as well as the monthly emails from CAQH ProView Updates.

Any provider choosing to not carry or renew a DEA Certificate must provide information to the Plan in this connection. Please complete the Prescribing Protocol form which is on the health plan website under - Providers - Tools & Resources - Forms - Provider Forms – DEA Protocol Form and give the completed form to your Provider Relations Representative.

The following items are updated and current as applicable:

- State Medical License(s) please include expiration date(s)
- Valid Insurance Information
- 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
- Questionnaire responses and explanations as required.
- DEA Certificate
- Practice locations
- Partners/Covering Colleagues

For Providers Not Part of the CAQH Proview:

The plan sends notification and re-credentialing applications by mail four months in advance of a providers scheduled re-credentialing date. The notification cover letter specifies the steps and documents needed for re-credentialing, as well as the deadline for the submission of all current information.

Active provider status is dependent upon completion of the re-credentialing process prior to the three-year expiration date.

Thank you for your timely submission!

.....and just a quick reminder, please promptly notify us of any change in your credentials.

2023 MTM Program Information

Medication Therapy Management (MTM) is a star score measure and we are on our way to 5 stars, but we are asking for some additional help from our providers to achieve our goal.

The Health Plan offers an MTM program for all its members who qualify based on specific eligibility criteria. The program includes a broad range of healthcare services provided by Clinical Pharmacists; including helping patients overcome barriers to adherence, addressing gaps in therapy, education on medications and disease states, reducing the use of unnecessary therapy, assessing for adverse effects, and advising on preventative measures.

MTM eligibility criteria is comprised of having a minimum of three (3) chronic diseases, eight (8) covered chronic/maintenance Part D drugs and incurring one-fourth of the specified annual cost threshold of $4,935 of Part D covered medications in the previous three months.

Our objective is to complete the member's comprehensive medication review within the first 60 days of MTM enrollment with the plan. Any member who chooses to opt-out of the MTM program within the 60-day timeframe will not count towards the denominator at the end of the year. Therefore, it is imperative to make outreach to those members who become eligible as soon as possible and remove opted out members from the program during this window of opportunity.

MTM eligibility files are released on a monthly basis, and you can find your members who remain eligible to complete their CMR for the year on the HEDIS portal.

We ask that you make outreach to your eligible members and advise of the importance of completing this medication review with one of our Health Plan pharmacists, and then transfer or provide them with our MTM department contact information **(813-506-6064)** to complete the medication review.

[1]CMS cut points below:

Type	Year	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
MAPD	2023	< 47 %	>= 47 % to < 67 %	>= 67 % to < 82 %	>= 82 % to < 89 %	≥ = 89

[1]Reference: 10/2022 Star Score Technical Specs

Lab Results As Quickly And Conveniently As Possible

At Labcorp, we want to make it easy for physicians to obtain lab results so that critical conversations about care plans happen early and often.

Results are reported to physicians after testing is completed and released by the lab. Routine tests are typically reported by 8:00 a.m. the next morning or within a few business days after specimen collection. Depending on the nature of the test(s), labs may take additional time if esoteric testing (e.g. genetic testing) is required.

Convenient ways to retrieve lab results

Dial the Labcorp customer service number (800-877-5227)

Select prompt for health care provider

Select prompt for test results

Enter Labcorp account number

Speak the patient name, date of birth and date of service when prompted

Results can be faxed to the number on file. At any time during the call, an agent can be readily available to assist. We value your feedback and have included an optional customer survey to rate your experience with our new service.

ADVANCE DIRECTIVES

A Patient's Right to Decide

According to state and federal laws, patients have the right to decide how they are medically treated, even if they are not able to speak or make their wishes known. The Plan does not condition treatment based on whether or not a patient has executed an advance directive. We expect our contracted providers to uphold this standard of non-discrimination as well.

In order to prepare for these situations in advance, we encourage our members to express their wishes by filing advance directives. It is a patient's individual choice whether or not to file an advance directive. Common types of advance directives include Living Wills, Health Care Surrogates and Anatomical Donations.

Remember, a patient's medical record must contain documentation of whether or not the individual has executed an advance directive; documentation is to be displayed in a prominent location in the record. The Plan and its providers are not required to provide care that conflicts with a Member's advance directives.

If your patients are interested in learning more about advance directives, you can refer them to the following resources:

✓ Donate Life Florida

Website: http://www.donatelifeflorida.org
This site offers information on organ and tissue donation as well as the option to register as a donor online.

✓ Florida Agency for Health Care Administration

Website: http://ahca.myflorida.com
This official website provides helpful information on Advance Directives, forms, and other resources.

✓ Florida Department of Elder Affairs

Website: https://elderaffairs.org/
Phone: 1-800-963-5337
Their website offers many resources for seniors including the Senior Legal Helpline: **1-888-895-7873**, a free legal consultation for seniors.

✓ The Florida Bar Association

Website: http://www.floridabar.org
The Florida Bar provides information for the public on certain general areas of law. This includes Advance Directives, Living Wills, and Health Care Surrogates. They provide helpful brochures, forms, and other useful information for healthcare planning.

✓ Aging with Dignity

Website: http://www.agingwithdignity.org
Phone: 888-5-WISHES (594-7437)
This organization has a document called Five Wishes. This document allows you to express how you want to be treated if you are seriously ill and unable to speak for yourself. This document meets the legal requirements of an Advance Directive in most states.

✓ Caring Connections

Website: http://www.caringinfo.org
Phone: (800) 658-8898
Caring Connections is a program of the National Hospice and Palliative Care Organization (NHPCO). This organization works to improve care at the end of life. Their website provides many resources for planning ahead. You can also download your state-specific Advance Directives.

Antidepressant Medication Management for PCPs

COMMON SYMPTOMS OF DEPRESSION

- Two weeks of persistently depressed mood
- Inability to feel pleasure
- Sleep difficulties
- Appetite and energy level changes
- Lost interest in activities
- Guilt and suicidal thoughts

Many people with depression are seen and treated in the primary care setting. Therefore, it is important for primary care physicians (PCPs) to screen patients for depressive symptoms. .

In addition to hallmark symptoms, many people with depression have vague somatic complaints, for which there's no disease explanation. Left untreated, comorbid depression can lead to poorer outcomes and prognosis of other diseases as well.

Three important factors help determine medication efficacy:

Deciding which antidepressant medication to use can be challenging.

1. COMPLIANCE. About 42 percent of patients discontinue their antidepressants during the first 30 days.

2. DURATION OF TREATMENT. An antidepressant can take 4-6 weeks to have a full effect, and a treatment episode should be at least six months after remission of symptoms or longer, depending on patient history.

3. ADEQUATE DOSING. Many antidepressants will need dosage adjustments to see full therapeutic effect. If seeing partial response, try increasing the dose before switching.

Presenting symptoms, comorbid conditions, and possible drug interactions should drive treatment decisions. If a person has had a prior good response to a medication, that medication should be initiated first. There are several classes of antidepressant medications: SSRIs, SNRIs, Tricyclics, MAOIs and atypical antidepressants. SSRIs and SNRIs, the most commonly prescribed antidepressants, have varying side effects, but nausea and headache are most common. To mitigate these transient side effects, start your patient at a low dose and titrate up as side effects subside.

Always see patients within a few weeks of initiating a medication to assess side effects, medication adherence and to screen for thoughts of self-harm. If a patient has thoughts of self-harm, refer that patient for immediate assessment. Carelon Behavioral Health can help with referrals to both inpatient and outpatient providers by calling **(888) 273-3710.**

For more information about various behavioral health topics, consult Carelon Behavioral Health's PCP toolkit by visiting https://www.carelonbehavioralhealth.com/providers/resources/provider-toolkit.

All About Member Care Plans

Every Spring, we distribute the Plan's Care Plan Manual Guide to our Primary Care Physicians (PCPs). Every member enrolled in a Special Needs Plan (SNP) receives an Individualized Care Plan (ICP) developed specifically for them. Risk stratification and resulting ICPs are generated based on member specific information, Health Assessment Tool (HAT) and Disease Specific Health Assessment Tool (DS-HAT) responses, and as needed additional member assessments, depending on the available information and level of member engagement. These Care Plans are described below.

Tier 1 Care Plans

Tier 1 Care Plans are developed and assigned to all SNP members based on their verified qualifying disease and/or dual-eligible status. These Care Plans are especially helpful during initial care transitions prior to receiving clinical assessment, updates, and subsequent claims, as well as for new members.

Supplemental Tier 1 Care Plans (Health Appraisal Profiles)

Health Appraisal Profiles (HAPs) are personalized Supplemental Care Plans generated for members completing and returning a general Health Assessment Tool (HAT). The HAP serves as a self-management Care Plan and allows members to track their health status and associated risk factors based on their responses to several health-related topics, such as overall health, emotional health, healthy behaviors, and preventive health activities. The HAP offers members improvement opportunities and additional resources on varied healthcare topics which empower them to take an active role in their health in collaboration with their Primary Care Physician (PCP) Medical Home.

Tier 2 Care Plans

Tier 2 Care Plans are developed utilizing member input, pharmacy data and claims experience. The member's answers to the Disease Specific Health Assessment Tool (DS-HAT) generate disease-specific problems with corresponding interventions and goals. The Care Plan includes the disease specific problem statement(s), interventions and goals, the self-reported disease health assessment, and the Member Summary. The Member Summary is developed from several sources including demographic data, claims, pharmacy, and lab data.

Tier 3 Care Plans

Tier 3 Care Plans are generated following telephonic interviews and assessments between at-risk members and specific Nurse/Social Work Case Managers. This in-depth assessment results from the HAT/DS-HAT responses or other Case Management/Disease Management referral triggers. The Care Plan is developed, discussed, and shared with the PCP, member/ caregiver and other necessary providers during finalization and ongoing updates. Tier 3 Care Plans are in addition to Tier 1 and 2 Care Plans. They represent the highest level of care for the most vulnerable enrollees.

Tier 1, HAP and Tier 2 Care Plans are all available to the member's current PCP on the Health Plan's MRA/HEDIS® Portal in the Care Plan section. Tier 3 Care Plans are faxed to the PCP at the time of creation, after material updates and upon case closure.

A Patient-Centered Approach

As a health plan that is always striving to improve our strategies in order to affect the health outcomes of your patients, we would like to share with you an approach that has been proven to work. The Patient-Centered Medical Home model (PCMH) and other similar models have been recognized for their various benefits to the patient, providers, health plans and the overall health care system. Two major advantages are maximizing health outcomes and cutting down unnecessary cost by putting the patient first.

Freedom Health/Optimum HealthCare supports and ascribes to a Medical Home Model. With the ongoing research and support from accrediting agencies, many practitioners have pursued the Accountable Care Organization (ACO) or PCMH accreditation to focus on positive patient outcomes. Florida providers, in particular, have taken increased initiative in implementing these models and thereby earning recognition for their commitment to their patients. You can review the list of over 1,000 practices in Florida on the National Committee for Quality Assurance (NCQA) site **(https://reportcards.ncqa.org)** who are dedicated to improving their patients' health.

For more information on why these accrediting programs are so widely adopted in the Country, please visit **http://www.ncqa.org/Programs/Recognition.aspx**

AUTHORIZATION REVIEW & DETERMINATION

Utilization Management (UM) department, including clinical staff, is available for all pre- certification requests and questions, Monday through Friday from 8:00 a.m. to 5:00 p.m. EST. Our staff is also on call after hours and on weekends to handle discharge planning requests from facilities and other emergent needs.

The UM Department uses the following criteria when making a determination for our Medicare members:

- Medicare National and Local Coverage Guidelines
- State Statutes, Laws and Regulations
- InterQual Criteria
- Hayes Medical Technology
- Policy/Benefit Coverage
- Medical Director professional judgment based on review of literature, evidence-based guidelines, & other Managed Care Organizations

FOR DUAL MEDICARE/ MEDICAID MEMBERS the UM Department also uses the Agency for Healthcare Administration (AHCA) and Medicaid Coverage and Limitation Guidelines.

In addition to using its own Medical Directors, the UM Department uses board-certified consultants as appropriate to assist in making medical necessity determinations.

TIMEFRAMES:

For standard requests, the Health Plan processes authorization requests as quickly as possible. Many of our requests are completed on the same day received, and our average turnaround time for all requests for service is less than 2 days. We urge our providers to include all necessary medical records when submitting a request in order to avoid unnecessary delays.

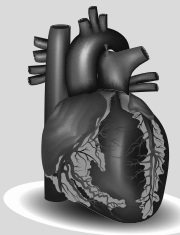
STANDARD REQUESTS MAY BE SUBMITTED BY FAX: 866-608-9860 OR 888-202-1940

For expedited requests, the review must be completed, including a notification to the member, within 72 hours from the time received at the Health Plan. Please note that a request should only be submitted as expedited if it is felt that waiting up to the standard time for a decision would place the patient's life, health or ability to regain maximum function in serious jeopardy.

EXPEDITED REQUESTS MAY BE SUBMITTED BY PHONE: 888-796-0947 OR BY FAX: 866-608-9860 OR 888-202-1940

HOW TO CHECK THE STATUS OF A REQUEST

- Access the Health Plan's Provider Portal, where you can review the status of a member's authorization request. If you have questions regarding the Provider Portal or would like access, please contact your Provider Relations representative for assistance; or
- Call the UM Department during normal business hours, 8:00 a.m. to 5:00 p.m. EST on weekdays, to check the status of a request.



REDUCING Readmissions for Members with CHF:

Chronic Care Improvement Program

Medicare Advantage (MA) organizations are required to conduct a Chronic Care Improvement Program (CCIP) initiative every three years. The Health Plan's 2022-2024 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.

We are in our second year of our current CCIP, and we are seeing a decrease in readmissions for some of our SNP populations. This is very promising however we still have more work to do. Our target population is Medicare members (individuals aged 65 or older or disabled) with a readmission having occurred within the past two years. Our goal is to reduce the potential for CHF related readmissions into any acute care inpatient facility.

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 incidence of CHF approaches 10 per 1,000 persons after the age of 65.

Referring your patients over to the Health Plan for inclusion in the CCIP is easy to do. Referrals can be made via the Provider Portal using the Case/Disease Management Referral Form or by having the member contact the Plan directly (the telephone number is on their Member ID Card) and asking for more information on Disease Management and the CCIP.

The CCIP is an included benefit giving members access to nurses that can provide Disease Management services at no additional cost. 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 and happy.

Progress of the CCIP is continually monitored for 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.

Requests for Additional Information on Organizational Determinations

When the Utilization Management (UM) Department receives a PCP's organizational determination request, complete clinical information from the member's health record is necessary to determine whether clinical guidelines for specific requested services are met.

UM uses phone and fax communication to reach out to providers. UM has a process and policy in place that mirrors CMS guidance, emphasizing that outreach be made as early in the coverage decision process as possible.

In order to assure rapid authorization turnaround times, the PCP should respond on the same day to information requests from UM. This is especially critical if the request is expedited. Quick response times from PCP's contribute significantly to our goal of completing all standard organizational determinations within 5 days.

This same process of PCP outreach occurs when requests for services are received from a provider other than a member's PCP. In these cases, UM will notify the member's PCP about the request, including the clinical information received with the request, and seek PCP review and input on the request.

If a PCP does not respond to an information request in a timely manner, the request and information will be forwarded to the Health Plan's Medical Director for a final decision. Having all relevant information available leads to more informed, accurate decisions, so timeliness of PCP response is important. A PCP's quick response to UM requests assure the Plan has relevant PCP medical records and clinical opinions for UM decision-making.

DON'T FORGET THE STATINS!

American College of Cardiology and American Heart Association (ACC/AHA) guidelines recommend moderate or high-intensity statins for adults with clinical atherosclerotic cardiovascular disease (ASCVD). Likewise, there are related quality measures that promote statin use in the CMS Medicare 2022 Part C & D Star Ratings.

The NCQA HEDIS® measure, "Statin Therapy for Patients with Cardiovascular Disease (SPC)," aims to encourage providers to prescribe the most effective drugs to treat high cholesterol in members with heart disease.

Specifically, this measure calculates the percentage of males 21-75 years of age and females 40-75 years of age in your patient population with clinical ASCVD, who were dispensed at least one high or moderate-intensity statin medication during the measurement year. The goal is to reduce major cardiovascular events in members who have been diagnosed with ASCVD.

The measure excludes members who:

- Were diagnosed with ESRD during the measurement year or the year prior.
- Were diagnosed with cirrhosis during the measurement year or the year prior.
- Were diagnosed with myalgia, myositis, myopathy or rhabdomyolysis during the measurement year.
- Had palliative care during the measurement year.
- Members in hospice or using hospice services during the measurement year.

Other exclusions which may not apply to many Medicare Advantage-age members are:

- Pregnancy or in vitro fertilization during the measurement year or the year prior.
- Members who were dispensed at least one prescription for clomiphene (Estrogen Agonist Medication) during the measurement year or the year prior.
- Medication) during the measurement year or the year prior.

Diabetics are another group at a higher risk for developing heart disease. The "Statin Use in Persons with Diabetes (SUPD)", which is adapted from the measure concept developed by the Pharmacy Quality Alliance (PQA), indicates most diabetics should take cholesterol medication to lower high cholesterol. Members between 40-75 years old who received at least two diabetes medication fills and received a statin medication fill during the measurement period are included in this measure. The measure excludes members who, during the measurement period:

- Were enrolled in hospice.
- Were diagnosed with ESRD or had dialysis coverage.
- Were diagnosed with rhabdomyolysis or myopathy.
- Were diagnosed with cirrhosis.
- Were diagnosed with pre-diabetes.

Other exclusions which may not apply to many Medicare Advantage-age members are those who:

- Were diagnosed with polycystic ovary syndrome (PCOS).
- Were pregnant, lactating or undergoing fertility treatments.

These generic statins have a $0 co-pay and are covered through the gap or "donut hole". They are also covered up to a 100-day supply:

- Atorvastatin
- Rosuvastatin
- Simvastatin
- Lovastatin
- Pravastatin

You prescribe the most effective medications because you care about your patients and want to help them avoid cardiovascular events and stay as healthy as possible. Proactive prescribing can also raise your HEDIS® scores and Star ratings. Do the best for your patients and your practice – don't forget the statins!

Population Health Management

When The Health Plan has a comprehensive Population Health Management (PHM) Strategy with member programs and services spanning the care continuum of health promotion and wellness for acute care, post-acute care, disease, and chronic illness management.

The cornerstone of our Population Health Strategy is an established primary care medical management model with patient centered medical homes. In this model, you, our providers as the member's personal physician are "in charge of overseeing and coordinating" the member's care are key contributors.

Our PHM Strategy addresses member needs in the following four areas of focus:

- Keeping members health
- Managing members with emerging risk
- Patient safety or outcomes across settings and
- Managing multiple chronic illnesses.

Members are informed about our PCP Medical Home Model in Sales and Marketing material, in the Plan Overview and in their EOC. The Plan supports and reinforces the PCP Medical Home Model throughout the organization. For example, when specialists or members approach the Plan directly to access services through authorization requests, the Plan reaches out to the PCP to facilitate PCP engagement and awareness of service requests. Similarly, all approved authorizations, regardless of the service provided, are communicated to the PCP as informational.

The Health Plan's PHM Strategy is supported by programs and activities that address member needs across the continuum of care and promotes health equity by closing care gaps that are unjust or avoidable. We want every member to have the opportunity to achieve the highest level of health possible. And, to make this possible, we have a shared responsibility to identify every opportunity to remediate care gaps.

Freedom Health and Optimum HealthCare work hard to help our members and providers overcome barriers to promote optimized health outcomes. We are proud of the many initiatives we have in place to provide fair access to health. To assure we are actively promoting and succeeding with our PHM Strategy, the Plan has annual goals tied to each of the program components. These goals collectively facilitate member/provider interaction and ongoing health plan support to both.

Gun Incidents in the Medical Office

Guns are pervasive and threats of gun violence are a reality. As a medical provider, one of your foremost duties is patient and staff safety. An effective office safety program involves identifying hazards, developing a plan to mitigate them, and having practice drills, thereby protecting people and premises. Certain factors may act as catalysts for gun incidents in medical offices:

- an anxious or angry patient or family member.
- long wait times, especially as the day progresses.
- patients/family left in waiting or exam rooms with no information or attention from staff.
- provider use of cell phones or computers, giving the impression of unconcern.

PLAN

- Call the police before a situation turns violent.
- Recognize that an incident might occur; formulate a plan for dealing with it.
- Review your plan with staff. Train staff to recognize signs of patient or family stress, including nonverbal language – and to defuse the situation with simple strategies: calming talk, a bottle of water or a separate waiting area.
- Evaluate the physical setup of the office and make changes if needed.
- Keep doors between waiting and exam areas locked, including the back door.
- Secure the reception area with a glass or heavy-duty plastic partition.
- Install cameras in waiting rooms and hallways.
- Give the front-desk person a code or alarm with which to alert others, and a list of emergency numbers.
- Ask a police officer to speak to staff about office security and de-escalation tactics.
- Post signs in the office that violence of any kind will not be tolerated and will be reported to the police.

PRACTICE

- Hold safety drills according to your written plan; change the plan as needed.
- Keep a record of your drills.

For more tips and guidelines, see OSHA's "Preventing Workplace Violence in Healthcare:" www.osha.gov/dsg/hospitals

Risks of Atypical Antipsychotics in the Diabetic Population

In the United States, the risk of type 2 diabetes has expanded exponentially. Although physicians are more adapted to the risk of diabetes among patients, most physicians are unaware that mental health disorders such as schizophrenia and bipolar are associated with the increased risk of diabetes.

The use of atypical antipsychotics in mental health disorders can increase the risk for metabolic syndrome. Metabolic syndrome incorporates changes such as weight gain, raised arterial pressure ≥ 160/90mmHg, hypertriglyceridemia, increased insulin, glucose, and LDL cholesterol levels.[1] Furthermore, treatment can lead to or worsen existing diabetes, and physicians need to be proactive when caring for patients who utilize these antiphychotic agents.

Adherence Concerns

The presence of type 2 diabetes and/or obesity could adversely affect patient compliance and lead to drug interruption, resulting in relapse and poor clinical outcomes. Moreover, weight gain enhances the social stigma associated with mental illness, and it often pushes the patients to abandon their treatments.[2]

It's imperative to combine these mental health regiments with therapy based on psychoeducation, physical exercise, and diet which have proven to be successful.

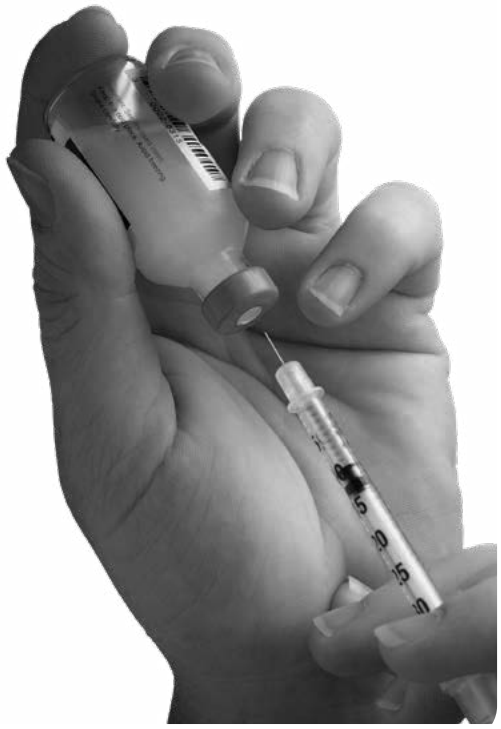
For those circumstances where non-pharmacologial treatments fail, fortunately, there are several pharmacological options available to treat metabolic syndrome in mental health patients.

Recommendations/Tips

Patient and physicians cooperation must occur to identify potential risk factors and to carefully monitor risks during treatment.

Monitoring tips for metabolic syndrome.[1]

- Weigh patients and track BMI at each visit.
- Get a baseline fasting glucose level and lipid profile for psychiatric patients who have a BMI ≥ 27 kg/m^2 and who are treated with psychotropic drugs, then track glucose and lipid levels at regular intervals, especially if further weight gain occurs.



- Monitor glucose levels frequently, including shortly after beginning a new psychotic agent.

Management tips for antipsychotic treatments.[3]

- Refer patients with abnormal glucose or lipid levels for medical consultation.
- Encourage weight loss.
- Be alert to the possibility of diabetic ketoacidosis.
- Leverage your therapeutic rapport to establish moderate exercise and discourage smoking whenever possible.

1. *Alberti K, Zimmet P. Definition, diagnosis, and classification of diabetes mellitus and its complications, pt 1: diagnosis and classification of diabetes mellitus provisional report of a WHO consultation. Diabet Med. 1998;15:539–553.*

2. *Carli M, Kolachalam S, Longoni B, Pintaudi A, Baldini M, Aringhieri S, Fasciani I, Annibale P, Maggio R, Scarselli M. Atypical Antipsychotics and Metabolic Syndrome: From Molecular Mechanisms to Clinical Differences. Pharmaceuticals. 2021; 14(3):238. https://doi.org/10.3390/ph14030238*

3. *Stahl S. The metabolic syndrome: psychopharmacologists should weigh the evidence for weighing the patient [BRAINSTORMS] J Clin Psychiatry. 2002;63:1094–1095.*

Spanish Language Access on the Plan *Website*

Our Spanish-speaking members account for the Plan's highest preferred language other than English. With that in mind, we have changed our Plan websites to help ensure that our members are equipped with the necessary tools to navigate the health care system.

We are proud that Freedom Health and Optimum Healthcare strive to have a more bilingual website presence. Our Plan websites at **www.freedomhealth.com** or **www.youroptimumhealthcare.com** are Spanish language enabled, making it easier to navigate to the information the members need. We continue to identify opportunities to make health plan information more accessible to all our members and look forward to sharing more about our achievements with our valued providers.

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.

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

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 or Social Workers 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. The Nurse or Social Worker, along with the member, develop a care plan which they send to the PCP, highlighting mutually agreed upon goals and interventions. They provide updates to the care plan when initiatives change.

Our Nurses and Social Workers 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!

PART D DISPLAY MEASURES

DISPLAY MEASURES 2024 STAR MEASURES

POPULATION HEALTH MANAGEMENT

Concurrent Use of Opioids and Benzodiazepines (COB)

The concurrent use of prescription opioids with benzodiazepines is deemed a serious safety concern for Part D beneficiaries. The CDC reported that opioids were associated with the most pharmaceutical related overdose deaths, followed by benzodiazepines. In addition, benzodiazepine use was associated with opioid overdose deaths and opioid use was associated with benzodiazepine overdose deaths. [1]

This combination can place an individual at a heightened risk for severe respiratory depression that can lead to death. These adverse events occur in both patients that do and do not demonstrate signs of drug abuse.

Despite concerns, the concurrent use of prescription opioids and benzodiazepines is prevalent in Medicare Part D enrollees.

Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH)

The concurrent use of multiple anticholinergics in older adults is associated with an increased risk of cognitive decline. Drugs with anticholinergic mechanisms of action are routinely prescribed in the elderly population due to their potential clinical benefits. However, serious adverse reactions may outweigh the benefits in certain circumstances.

Anticholinergics can ultimately affect cognition in both healthy and cognitively impaired patients. It can additionally lead to the development of psychiatric symptoms and have influence over functionality, hospitalization, institutionalization, and mortality.

Polypharmacy: Use of Multiple CNS-Active Medications in Older Adults (Poly-CNS)

The concurrent use of multiple CNS active medications in older adults is associated with an increased risk of falls. Benzodiazepines and other CNS-active treatments are often prescribed with opioids to magnify analgesic effects and/or manage insomnia, anxiety, and other mental health disorders commonly associated with chronic pain.

There are established adverse risks associated with concurrent use, notably respiratory depression, subsequently associated with overdose deaths, altered mental states affecting vehicle safety, and postural stability associated with falls/fractures in those aged ≥ 65 years. [2]

RECOMMENDATIONS

Better awareness of the adverse effects associated with opioids, benzodiazepines, anticholinergics, and CNS-active agents is warranted. This will benefit both the patient and provider. More evidence-based non-pharmacological options to address anxiety, insomnia, and pain symptoms is necessary to combat the adverse events caused by dangerous treatment combination regimens.

1. Jones CM, Mack KM, Paulozzi LJ. Pharmaceutical Overdose Deaths, United States, 2010 JAMA. 2013; 309(7):657-659. doi:10.1001/jama.2013.272
2. Dowell D, Haegerich TM, Chou R. CDC guideline for prescribing opioids for chronic pain—United States, 2016. MMWR Recomm Rep 2016;65:1–49

Evidence-based Clinical Practice Guidelines

The Plan reviews and adopts Evidence-based Clinical Practice guidelines in consultation with the Plan's Manager Medical Director and/or Medical Director(s), a panel of physicians, an interdisciplinary care team of board-certified specialists and the Quality Management Steering Committee.

The Plan utilizes evidence-based clinical practice guidelines on which it bases its management of members' health care needs, including the development of all disease-based assessments, education of members on suggested self-care, condition monitoring and care plans.

The Plan updates its practice guidelines periodically and reviews them at least annually. National agencies and medical specialty societies also adopt evidence-based clinical practice guidelines. They are based on reasonable medical evidence or the consensus of physicians in a particular field.

Adapted to the needs of the Plan's members, the guidelines are included in the Care Plan Manual sent to primary care providers. They are available to members when appropriate and upon request. A copy of the evidence-based clinical practice guidelines and the links to their sources are available on the Plan's websites at:

www.freedomhealth.com -> Providers -> Tools & Resources - > Clinical Healthcare - > Clinical Practice Guidelines

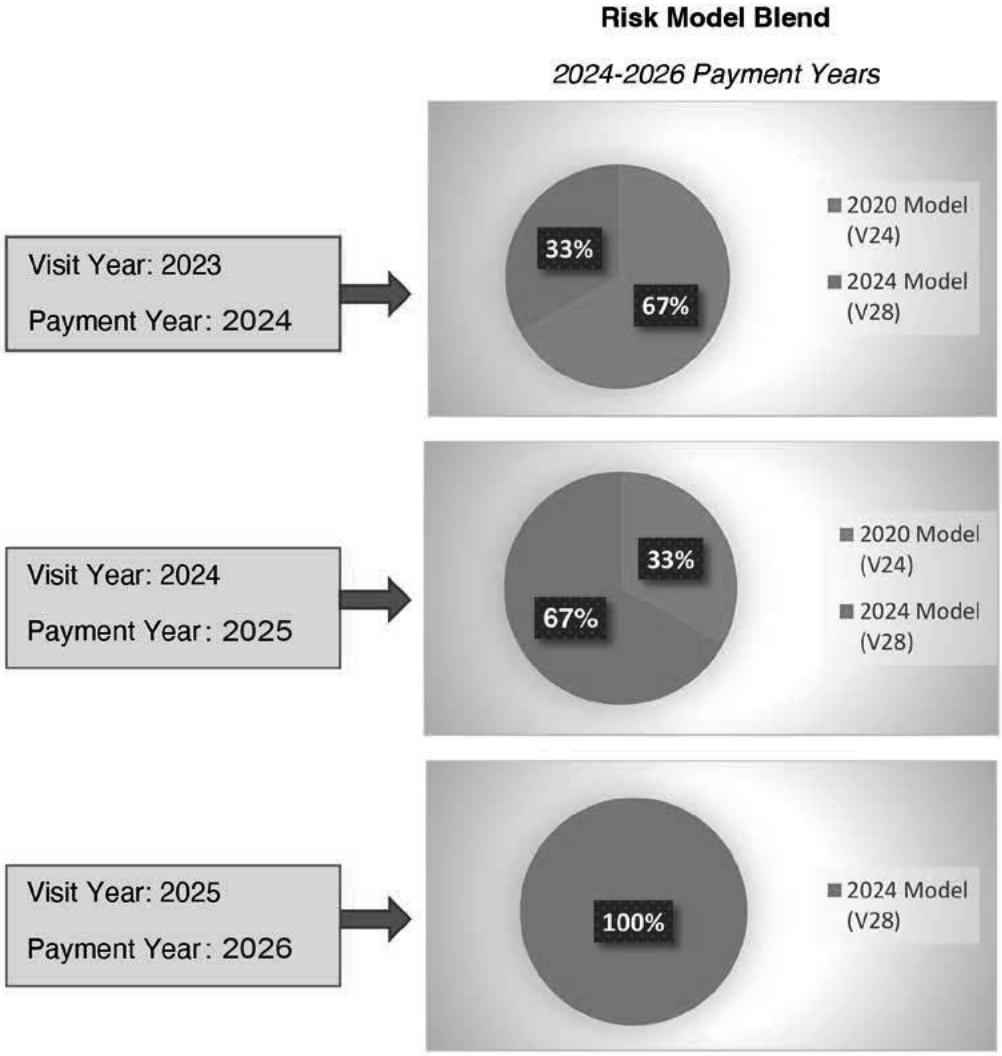
www.youroptimumhealthcare.com -> Providers -> Tools & Resources - > Clinical Healthcare - > Clinical Practice Guidelines

2024 CMS-HCC V28 Risk Adjustment Model

On March 31, 2023, CMS announced the new 2024 CMS-HCC V28 Risk Adjustment Model beginning in payment year 2024 with 2023 dates of service. The V28 Model has been updated using 2018 ICD-10 diagnosis data versus the 2020 CMS-HCC V24 Model which is based on 2014 ICD-9 diagnosis data. The revised model includes clinically based adjustments to ensure that conditions included in the model are stable predictors of cost.

The number of HCCs included for payment in the 2024 CMS-HCC V28 Risk Adjustment Model has increased from 86 to 115 HCCs. Many HCCs have been renumbered and adjustments made to the associated HCC relative factors. Diagnoses codes included within the payment model have also been reevaluated, resulting in a decrease in ICD-10 codes from 9,797 to 7,720 that risk adjust under the new model.

The 2024 CMS-HCC V28 Risk Adjustment Model will be implemented over the course of the next three years using a phase-in approach. Risk Scores will be calculated as a blend of the two models until payment year 2026 when the new 2024 CMS-HCC V28 Risk Adjustment Model will be fully implemented.



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provider NEWS

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