provider **report**

SUNSHINE STATE® Health Plan

WINTER 2012

Online Access

Did you know that contracted Sunshine State Health Plan providers may save valuable time and access information online through our provider web portal?

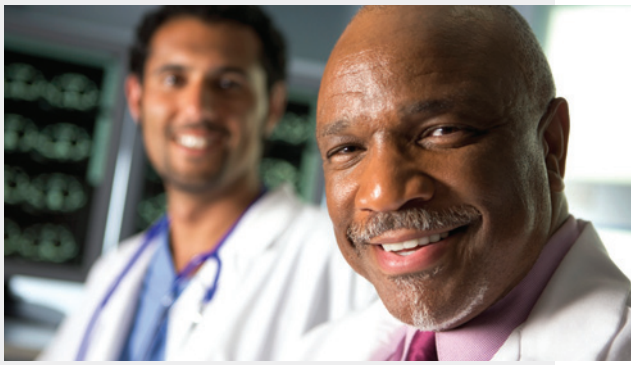
You can do the following by accessing our online portal:

- View your member roster with Sunshine State Health Plan
- Check eligibility for the members assigned to you
- Obtain authorization status for members
- Submit a request for an authorization
- Check claim status–view *all* claims submitted through the web portal
- Enter a UB claim
- Enter an HCFA claim
- View payments
- Print any forms that are available for the member
- Use our claim auditing software when a procedure code is in question
- Take advantage of training and educational materials available to providers
- Use the CONTACT US feature, which lets providers send a message with any question he or she might have

For more information on obtaining access, please contact your provider relations representative directly, or call us at 1-866-796-0530 so we can help you get access and training.

Peer-to-Peer Review

We will send you notification of any changes in a member's coverage.



Sunshine Health will send you and your patient written notification any time we make a decision to deny, reduce, suspend or stop coverage of certain services. The denial notice includes information on the availability of a Sunshine Health medical director to discuss the denial decision.

In the event that a request for medical services is denied due to lack of medical necessity, a provider can request a peer-to-peer review with our medical director on the member's behalf. The medical director may be contacted by calling Sunshine Health at 1-866-796-0530. A care manager may also coordinate communication between the medical director and the requesting practitioner as needed.

The denial notice will also inform you and the member about how to file an appeal and how to contact Sunshine Health if assistance is needed. In urgent cases, an expedited appeal is available and can be submitted verbally or in writing.

Your Right to Review and Correct Information

During the credentialing and recredentialing process, Sunshine Health obtains information from various outside sources, such as state licensing agencies and the National Practitioner Data Bank. Practitioners have the right to review primary source materials collected during this process. The information may be released to practitioners only after a written and signed request has been submitted to the Credentialing Department.

Also, if any information gathered as part of the primary source verification process differs from data submitted by the practitioner on the credentialing application, Sunshine Health will notify the practitioner and request clarification. A written explanation detailing the error or the difference in information must be submitted to Sunshine Health within 14 days of notification of the discrepancy in order to be included as part of the credentialing and recredentialing process.

Providers also have the right to request the status of their credentialing or recredentialing application at any time by contacting the Sunshine Health Credentialing Department at 1-866-796-0530.

What Is HEDIS?

HEDIS is a set of standardized performance measures, updated and published annually by the National Committee for Quality Assurance (NCQA). HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. HEDIS is designed to provide purchasers and consumers with the information they need to reliably compare the performance of health care plans. Final HEDIS rates are reported to NCQA and state agencies in June of each year. However, Sunshine Health reviews HEDIS rates on an ongoing basis and continually looks for ways to improve rates, as part of our commitment to providing access to high-quality and appropriate care to our members.

On this page and the next, we offer a summary of the HEDIS measures related to cardiac and diabetic patients, and how we can work together to deliver the best care to these patients.

Cardiac Care

Take note of these measures regarding beta-blocker treatment as well as cholesterol and high blood pressure management.

➔ The HEDIS measure for persistence of beta-blocker treatment after heart attack applies to patients who were hospitalized and discharged after an acute myocardial infarction (AMI). It calls for treatment with beta-blockers for six months after discharge. Patients with a known contraindication or a history of adverse reactions to beta-blocker therapy are excluded from the measure.

Despite strong evidence that use of beta-blockers after AMI has been shown to reduce the risk of rehospitalization and death from subsequent attacks within the first two years, patient compliance remains a challenge—particularly among Medicaid patients.

➔ Cholesterol management is a HEDIS measure that applies to any patient who has been discharged with AMI, coronary artery bypass graft or percutaneous coronary interventions, or who has a diagnosis of ischemic vascular disease. The HEDIS rate measures the percentage of these patients who had an LDL-C screening performed during the calendar year, and the percentage of those patients with an LDL level less than 100 mg/dL.

➔ The HEDIS measure that calls for high blood pressure control applies to patients who have been diagnosed with hypertension (excluding individuals with end stage renal disease and pregnant women). The HEDIS rate is measuring the percentage of hypertensive patients with adequate control (defined as a systolic reading of less than 140 mm Hg and a diastolic reading of less than 90 mm Hg).

STEPS YOU CAN TAKE

Continue to stress the value of prescribed medications for CVD patients at every appointment and inquire about side effects; continue to offer education and support related to other cardiac risk factors such as smoking, high blood pressure, obesity or family history of heart disease, and the importance of exercise and nutrition. If possible, coordinate with pharmacies to remind patients to fill or refill prescriptions. Sunshine Health can also provide educational materials and other resources addressing the above topics. Please encourage your Sunshine Health patients to contact us for assistance in managing their cardiovascular disease.

Sunshine Health case management staff can assist with patients who have challenges adhering to prescribed medications or have difficulty filling their prescriptions. Contact Sunshine Health if you have a member you feel could benefit from our case management program.

Diabetic Care

There are opportunities to improve treatment of adults with Type 1 or Type 2 diabetes.

The HEDIS measure for comprehensive diabetes care includes adult patients with Type 1 and Type 2 diabetes. There are multiple sub-measures included:

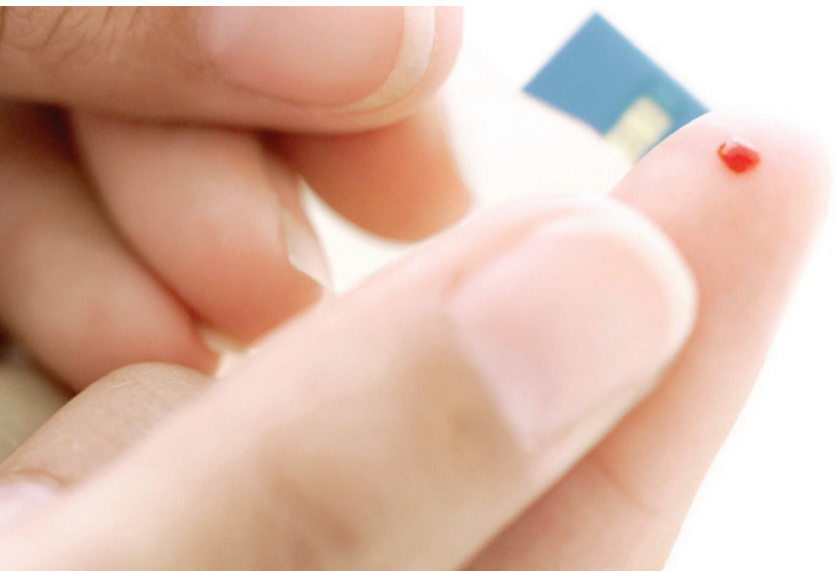
- **HbA1c testing:** completed at least annually
- **HbA1c level:**
  - HbA1c result > 9.0 = poor control (CPT II code 3046F)
  - HbA1c result < 8.0 = good control (CPT II code 3044F)
  - HbA1c result < 7.0 for selected population (CPT code 3044F)
- **LDL-C testing:** completed at least annually
  - LDL-C result < 100 (CPT code 3048F)
- **Dilated retinal eye exam:** annually, unless prior negative exam; then every 2 years
- **Nephropathy screening test:** at least annually (unless documented evidence of nephropathy)

In analyzing our data surrounding comprehensive diabetic care, Sunshine Health found many patients receive HbA1c testing, but these same patients are missing the LDL screening. When identifying opportunities for improvement, several questions arose: Is LDL testing not ordered? Do providers order LDL testing, but patients do not have their blood drawn? Do patients forget to fast; therefore the LDL testing is not performed at the same time the HbA1c is completed?

HbA1c & LDL-C testing: A reminder to fast and stressing the importance of having both tests drawn at the same time may help patients with compliance. Sunshine Health has ongoing efforts to educate our diabetic members about the importance of both these tests.

Dilated retinal eye exam: Sunshine Health can assist your office with finding a vision provider for your patients if needed. Our vision vendors are helping in our efforts by contacting members in need of retinal eye exams to assist them in scheduling an appointment.

Nephropathy screening test: Did you know a spot urine dipstick for microalbumin or a random urine for protein/creatinine ratio are two methods which meet the requirement for nephropathy screening? These may be appropriate tests for those patients you feel do not require a 24-hour urine test.



ADVANCE DIRECTIVES

What's Your Responsibility?

Sunshine Health wants to ensure our members are getting information about advance directives, as well as their right to execute these important documents. Sunshine Health educates our members about advance directives regardless of health status; when providers also take advantage of opportunities to discuss advance directives when their patients are healthy, it can make the topic more comfortable.

It's critical that providers and office staff are aware of, and comply with, their responsibilities under federal and state law regarding advance directives. Providers are required to document provision of information, and whether the patient has arranged an advance directive, in his or her permanent medical record.

During our medical record compliance audits, Sunshine Health will randomly monitor compliance with this provision. Please contact us if you would like general information about advance directives or in regards to a specific member.

COVERAGE POINT:
New Technology

Sunshine Health may provide coverage for new technology medical services or procedures that are not considered investigational or experimental. Sunshine Health evaluates the inclusion of new technology and new application of existing technology for coverage determination on an ongoing basis. This may include medical and behavioral health procedures, pharmaceuticals and/or devices.

Requests for coverage will be reviewed and a determination made regarding any benefit changes that are indicated. When a request is made for new technology coverage on an individual case and a plan-wide coverage decision has not been made, Sunshine Health will review all information and make a determination on whether the request can be covered under the member's current benefits, based on the most recent scientific information available.

FOLLOWING FEEDBACK:

How We Rate With Your Patients

Results from the Member Satisfaction Survey guide our initiatives for improvement.

Sunshine Health recently completed a satisfaction survey. Overall, we scored 62.1 percent compared to the 2011 NCQA national benchmark, in the Rating of Health Plan. This is due to the excellent network of physicians that care for our members. We appreciate your efforts and thank you for helping us reach these scores.

Areas where we stood out include:

ADULT SURVEY

- Getting Care Quickly (Appointments)
- How Well Doctors Communicate
- Customer Service
- Coordination of Care
- Health Promotion and Education
- Rating of Health Plan and Health Care
- Rating of Personal Doctor

CHILD SURVEY

- Getting Needed Care (Authorizations and Specialist Appointments)
- Getting Care Quickly (Appointments)
- Health Promotion and Education
- Rating of Health Plan and Health Care

These survey findings will be shared with members of our Member Advisory Committee for their input. As you know, surveys are completed annually and reflect how our members feel about the care they receive from our providers as well as the service they receive from the health plan.

Sunshine Health takes our members' concerns very seriously and will work with you to improve their satisfaction throughout 2012.

GET UP TO SPEED: Visit sunshinestatehealth.com for resources and tools to help you and your staff work more efficiently.

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FL-SSHP-PRWTR-Q1_12