The Quality of Care

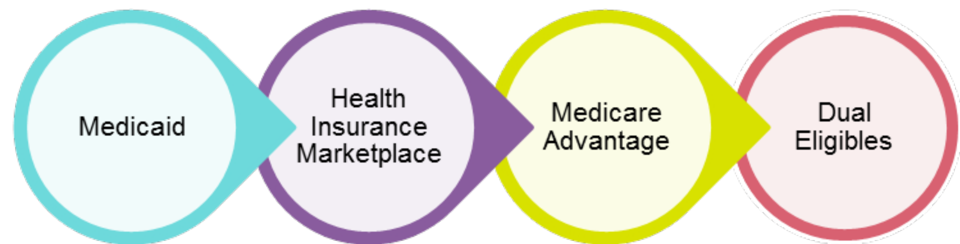
Health Partner Information

Our MISSION

To make a lasting difference in our members' lives by improving their health and well-being.

CARESOURCE

- A nonprofit health plan and national leader in Managed Care
- Nearly 30-year history of serving the low-income populations across multiple states and insurance products
- Currently serving over 2.1 million members in Kentucky, Ohio, Indiana, West Virginia and North Carolina.



2.1M members

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Clinical Operations

Medical Affairs

Medical Affairs provides clinical leadership within our markets and enterprise functions. Our Medical Directors provide the Utilization Management, Care Management, and Appeals departments with consultative expertise in the development of clinical programs, services and initiatives.

Additionally, Medical Directors participate in medical necessity review, perform case rounds, clinical policy review, peer to peer, integration with providers in each market to build the clinical policy and participate in interdisciplinary care teams.

To Connect with Our Medical Director,
Call 1-502-377-0607

Provider Portal

Improving Health Outcomes
Provider Portal Tools

At CareSource, we want to make it easy for you!

With quick and convenient access to our secure Provider Portal, we are working to partner with you to improve patient outcomes efficiently.

Key Benefits of Provider Portal

Clinical Practice Registry	Payment History
Member Profile	Explanation of Payment
Provider Toolkit	Prior Authorization
Member Eligibility & Termination	Care Treatment Plans
Claims Information	Care/Disease Management Referrals
Coordination of Benefits	Member Dental History

Register for the Provider Portal

The Provider Portal makes it easier for you to work with us 24/7. It has critical information and tools to save your practice time. This helpful online tool is available for all CareSource Ohio plans.

If you are not already registered for the Provider Portal, please register here. You can refer to the Portal Registration Training Module for step-by-step instructions.

If you have a login but cannot remember your username and/or password, please call the CareSource Provider Services Department at 1-800-488-0134.

Browser Requirements for the CareSource Provider Portal

In order to use the CareSource Provider Portal, you must use Internet Explorer browser version 8, 9, 10 or 11. We do not support Internet Explorer version 7. You may also use Google Chrome and FireFox browsers.

Provider Login:

Username: *

Password: *

Log In

https://www.caresource.com/providers/provider-portal/

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Improving Health Outcomes
Provider Portal Tools

Provider Portal Training

PROVIDER PORTAL

/ Users / Provider Training

MEMBER SEARCH +

CLAIMS +

MEMBER REPORTS +

USERS -

Update My Account

Provider Training

PROVIDERS +

ASSESSMENTS +

PROVIDER PORTAL

/ Users / Provider Training

MEMBER SEARCH +

CLAIMS +

MEMBER REPORTS +

USERS -

Account Linker

Manage Users

Update My Account

Impersonate User

Provider Training

Edit

Provider Training And Attestation

Model of Care

Provider Portal Resource Library

CareSource wants you to have the tools you need to manage your CareSource members in an efficient and timesaving manner. The Provider Portal makes it easy for you to work with us 24/7 and has critical information and tools to save your practice time.

Access the links below to learn about resources on the portal, how to use them and which ones will work best for your practice!

If you are having trouble viewing the training materials and are using Chrome, please try to use Firefox or Internet Explorer.

Using the Provider Portal

- Provider Portal User Guide
- CareSource Portal User Submission Guide
- Portal Introduction Video
- HCFA Online Form Video
- UB Online Form Video
- Dental Online Form Video
- Resubmit, Upload Image, Reports Video
- Clinical Practice Registry

The Provider Portal provides training options for most portal tools. To access training, click on Users > **Provider Training** on the menu to the left on your **Provider Portal** homepage.

Clinical Practice Registry

Clinical Practice Registry (CPR)

The CPR
is an online tool that helps identify:

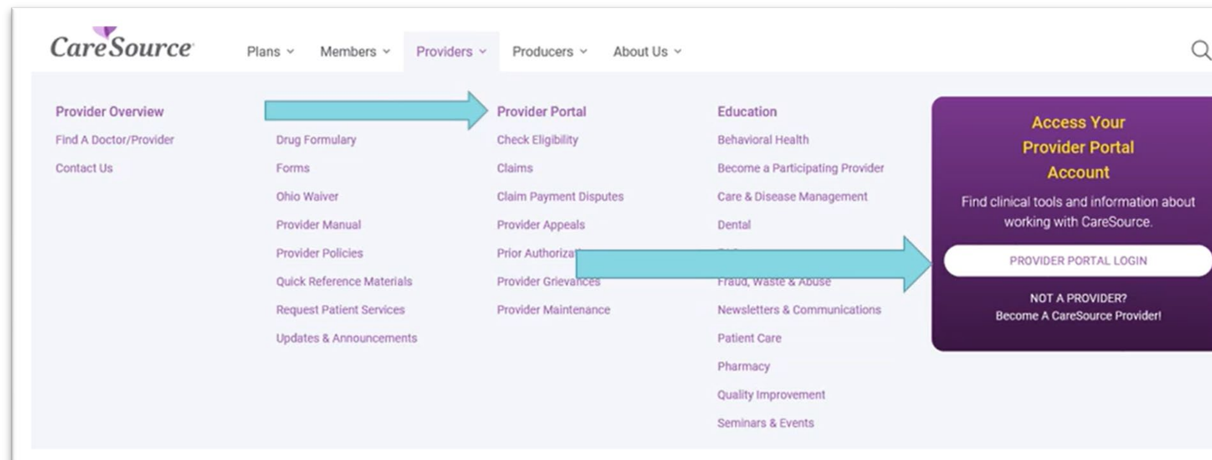
Members under your care

Current & potential gaps in care

Services that apply to quality metrics

Access the CPR via Provider Portal

- Visit CareSource.com
- Select Providers
- Click Provider Login
- Then click Provider Portal



Clinical Practice Registry (CPR)

CPR – On Demand Tool via Provider Portal

PROVIDER PORTAL

/ Member Reports / Clinical Practice Registry

MEMBER SEARCH -

Member Eligibility

Coordination of Benefits

Member File Upload

CLAIMS +

MEMBER REPORTS -

Provider Membership List

Clinical Practice Registry

The registry is color-coded, so you can easily identify areas of focus for your patients:

- Green Service was rendered
- Yellow Service needed
- Red Service past due
- Grey Not applicable

Patient gaps in care are highlighted in red

Compliant areas are also highlighted in green

At risk areas are identified in yellow

- Login Information: Username & Password
- Choose *Member Reports* then click *Clinical Practice Registry*
- Multiple options for filtering by measure, gap status, and patient status (new or established).

Included Measures

- Asthma
- Adult access
- Beta blocker
- Breast cancer screening
- Cervical cancer screening
- Colorectal cancer screening
- Chlamydia screening
- Eye exam (diabetes)
- A1C (diabetes)
- Kidney Health Evaluation (diabetes)
- Emergency room usage
- Well-child visits (First 30 months) (# of visits and date of service)
- Well-care (3 to 21 years)

Data is updated monthly based on received claims data

Claims data is determined by the Date of Service on the claim through the end of the previous month.

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Member Care *Alerts*

CareSource

Switch to State-Specific Portal

Provider Portal – Member Reports – Clinical Practice Registry

Clinical Practice Registry

Clinical Practice Registry

Clinical Practice Registry Definitions

Providers: Provider Name

Filters

Select State	Select Plans	Select Measures	Select Criteria	Select Patient Status	Select Enrollment Status
All	All	All	All	All	All
Georgia	Marketplace	Adult Access	Red	Established	Continuous
Indiana	Medicaid	Asthma Control	Yellow	New	Recent

Page(s): 1 2 3 4 5 6 7 8 9 10 ...

Member Name	Member ID	DOB	Sex	State	Plan	LOB	Adult Access	Asthma Control	Beta Blocker	Breast Cancer	Cervical Cancer	Colorectal Cancer	Chlamydia	Diabetes Eye Exam	Diabetes A1C	Diabetes Kidney Function	ER
Member Sample Name			M	IN	Medicaid	HHW											
			M	IN	Medicaid	HIP											
			F	IN	Medicaid	HIP											
			M	IN	Medicaid	HIP											
			M	IN	Marketplace		6/23/2017					3/8/2016			4/6/2017	7/1/2017	

There are also ***member-specific*** alerts.

To see a member's Gap in Care alerts, click on Member's name.

By clicking on a patient's name, you have access to patient specific information.

These alerts can help identify current or potential Gaps in Care for a specific member.

Export Data

Clinical Practice Registry

Export Clinical Practice Registry: PDF / CSV

Click

PDF
Download up to 500 patients at a time. This version cannot be edited.

CVS file (EXCEL)
You can download up to 1,500 records at a time, edit the content and access patient contact information.

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Clinical Practice Guidelines

Clinical Practice
Guidelines

CareSource approves and adopts nationally accepted standards and guidelines and promotes them to practitioners and members to help inform and guide clinical care provided to CareSource members.

Provider

Clinical Practice Guidelines

ATTENTION-DEFICIT/ HYPERACTIVITY DISORDER CLINICAL PRACTICE GUIDELINE

American Academy of Pediatrics

HYPERTENSION

American Heart Association & International Society for Hypertension

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Provider
Clinical Practice Guidelines (CPGs)

CareSource approves and adopts evidence-based nationally accepted standards of care and CPGs to help inform & guide the provision of clinical care to members. Review occurs once a year and guideline updates are reviewed and approved by the Market Provider Advisory Committee.

CPGs may include, but are not limited to:

- Behavioral health
- Chronic Health Conditions
- Adult Preventive and Maternal/Child Health Care

KY | Plans | Members | Providers | Producers & Navigators | About Us

CareSource / Kentucky / Provider Overview / Education / Patient Care / Health Care Links — Currently viewing: Kentucky, Marketplace

BEHAVIORAL HEALTH +
PHARMACY
DENTAL
LABORATORY
HEALTH CARE LINKS
UTILIZATION MANAGEMENT

QUICK LINKS
Provider Portal Registration Guide
Provider Login
Procedure Code Lookup Tool
Formulary Search Tool
Policies
Updates & Announcements
Find a Doctor/Provider
COVID-19 Information

Clinical Practice Guidelines

Health Condition	Clinical Guideline
Asthma	2020 Focused Updates to the Asthma Management Guidelines: A Report from the National Asthma Education and Prevention Program Coordinating Committee Expert Panel Working Group. At-A Glance Guide-Asthma Management Guidelines (2020 Focused Updates) National Heart, Lung and Blood Institute, National Institutes of Health
Blood Cholesterol	2018 Guideline on the Management of Blood Cholesterol: Executive Summary The American Heart Association, American College of Cardiology, American Association of Cardiovascular & Pulmonary Rehabilitation, American Academy of Physician Assistants, Association of Black Cardiologists, American College of Preventive Medicine, et al. *The American Heart Association is a national voluntary health agency to help reduce disability and death from cardiovascular diseases and stroke.*
Chronic Obstructive Pulmonary Disease (COPD)	Global Strategy for the Diagnosis, Management and Prevention of Chronic Obstructive Pulmonary Disease 2023 Report Global Initiative for Chronic Obstructive Pulmonary Disease (GOLD)
	2019 ACC/AHA Guideline on Primary Prevention of Cardiovascular Disease: Executive Summary American College of Cardiology and American Heart Association Task Force on Clinical

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Member Experience

What is QHPEE?

CAHPS[1] for Marketplace is called the "QHPEE" Survey.

It's a *survey* taken by CareSource Marketplace members, with core questions derived from the CAHPS®[1] survey that CMS[2] uses as part of the criteria for measuring the quality of Health Plans.

Qualified Health Plan Enrollee Experience Survey

Annual survey taken by members from **February-May**

Members receive the survey first by **mail***, then by email and phone formats*

Sent to members by CMS certified vendor, **Press Ganey**

Members asked and to **rate their CareSource health plan, providers and overall health care** *questions about their healthcare experiences*

Members are **randomly selected** *& answers kept* **anonymous**

The data collected is used towards CMS's Quality Rating System (QRS) **Stars Ratings** *published on healthcare.govin October for the public to be able to assess a health plan's quality as they are choosing their health plan for the upcoming year.*

CareSource Marketplace markets surveyed: OH, IN, KY, WV, GA

[1]The Consumer Assessment of Healthcare Providers and Systems, CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)

[2]Centers for Medicare and Medicaid (CMS)

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QHPEE and Patient Experience

The QHPEE survey covers a full circle of a patient's care journey, from access to delivery and follow-up.

WHAT	HOW

PRE-CARE EXPERIENCE

1. It was easy to schedule my appointment.
2. I got the care I needed when I needed it.
3. My appointment began within 15 minutes of the scheduled time.

- Help patients obtain timely appointments with EASE
- Offer FLEXIBLE care options
- MINIMIZE patient wait times

DURING-CARE EXPERIENCE

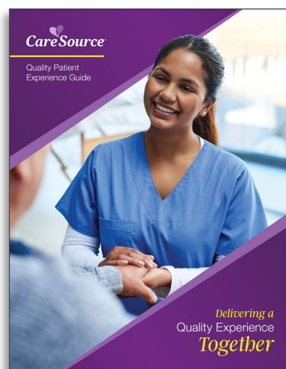
4. My healthcare provider is informed and ready to deliver my care.
5. My healthcare provider understands and cares about my needs.
6. My healthcare provider gives me the information and support needed to effectively manage my care.

- Ensure READINESS to deliver needed care
- Communicate with EMPATHY
- Empower patients with helpful INFORMATION

AFTER-CARE EXPERIENCE

7. My healthcare provider followed-up within an appropriate timeframe about my health and are needs.

- Provide courteous and timely FOLLOW-UP



Keep a copy of our Quality Patient Experience Guide to use as a helpful reference on QHPEE!
OH, IN, GA, KY, WV

Improve QHPEE/CAHPS Scores

Keep These Tips in Mind:

Minimize door-to-provider times as much as possible.

Let patients know how to get care after hours.

Offer to schedule specialist appointments while patient is in the office and discuss expected wait time and address needs covering that timeframe.

Remember, it’s just as important to explain why you are not doing something as it is to explain what you are doing.

Invite questions and encourage patients to take notes.

Call with test results as soon as possible.

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Quality Metrics

What is HEDIS®?

Healthcare
Effectiveness
Data and
Information
Set®

CareSource monitors member quality of care, health outcomes, and satisfaction through the collection, analysis and the annual review of the Healthcare Effectiveness Data and Information Set® (HEDIS®).

HEDIS® is one of the most widely used sets of health care performance measures in the United States.

- Developed and maintained by the National Committee of Quality Assurance (NCQA).
- Includes 90+ measures across six domains of care.
- Makes it possible to compare the performance of health plans on an "apple-to-apples" basis.
- Generally, measures health plan performance over the past year.

122 Controlling High Blood Pressure

Controlling High Blood Pressure (CBP)

Summary of Changes to HEDIS 2018

- Added required exclusions to the Medicare product line for members 65 years of age and older living long-term in institutional settings.
- Clarified that a diagnosis code for hypertension documented in the medical record may be used to confirm the diagnosis of hypertension.
- Clarified that the pregnancy optional exclusion should be applied to only female members.
- Replaced medication table references with references to medication lists.
- Revised the language in step 1 of the Numerator and added *Notes* clarifying the intent when excluding BP readings from the numerator.
- Revised the Data Elements for Reporting table to reflect the removal of the Final Sample Size (FSS) when reporting using the hybrid methodology.

Description

The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year based on the following criteria:

- Members 18–59 years of age whose BP was <140/90 mm Hg.
- Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg.
- Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg.

Note: *Use the Hybrid Method for this measure. A single rate is reported and is the sum of all three groups.*

Definitions

Adequate control	Adequate control is defined as meeting any of the following criteria: • Members 18–59 years of age whose BP was <140/90 mm Hg. • Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg. • Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg.
Representative BP	The most recent BP reading during the measurement year (as long as it occurred after the diagnosis of hypertension). If multiple BP measurements occur on the same date, or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. If no BP is recorded during the measurement year, assume that the member is "not controlled."

Eligible Population

Note: *Members in hospice are excluded from the eligible population. If a member is found to be in hospice or using hospice services during medical record review,* the member is removed from the sample and replaced by a member from the oversample. *Refer to General Guideline 20: Members in Hospice.*

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	18–85 years as of December 31 of the measurement year.

HEDIS 2018, Volume 2

Technical Specifications

- NCQA provides HEDIS® technical specifications for all measures.
- These specifications **define** all aspects of measure composition, measure data collection, and measure reporting.
- The tech specs indicate the measure's *lookback period* which defines the time parameters associated with each measure.

Healthcare Effectiveness Data and Information Set (HEDIS)

Quality *Measures*

HEDIS® MEASURES

HEDIS® includes a multitude of measures that look at different domains of care:

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Risk Adjusted Utilization
- Health Plan Descriptive Information
- Measures Reported Using Electronic Data Systems

EXAMPLE OF MEASURES

Wellness & Prevention

- Child, adolescent, and adult immunization
- Immunizations for adolescents
- Breast cancer and cervical cancer screenings
- Colorectal cancer screening

Diabetes and Cardiovascular Conditions

- Controlling high blood pressure
- Comprehensive diabetes care (A1C, Eye, Kidney)
- Statin therapy for patients with cardiovascular disease or diabetes

Behavioral Health

- Follow-up after hospitalization for mental illness
- Depression screening and follow-up

Access to Care

- Children and adolescents' access to primary care providers
- Oral evaluation
- Prenatal and postpartum care

QHPEES/ CAHPS Survey

QHPEES is a survey of member experience & satisfaction. It focuses on:

QHPEES

- Key components of health care quality
- Aspects of quality that patients find important
- Reporting information to the public in a meaningful way

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Quality Rating Systems (QRS) *Marketplace*

Quality Rating Systems (QRS) is used by CMS to measure how well Marketplace plans perform. The information is posted to the CMS website for consumers to compare the quality of health plans.

QRS Measures

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Quality & Quality Metrics – Working Together

Practice Standards:

- Clinical Practice Guidelines
- Evidenced Based Care
- Best Practice
- Professionalism

Practice Standards ⟷ **Metric Targets**

Metric Targets:

- HEDIS
- Stars
- QRS
- NCQA
- QHPEES
- Accreditation

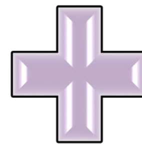
By following **Practice Standards**, we achieve our **Metric Targets**, and by achieving our **Metric Targets**, we follow **Practice Standards**.

What are Quality Metrics?

When we refer to quality metrics, we are looking at information pulled from two places:

In this case, we are measuring:
Care Provided with Outcomes
HEDIS Measures
QRS

- Claims
- RX data
- Lab data
- Medical records



Quality Metrics

In this case, we are measuring:
Member Experience of Care
QHPEES

Member Surveys

CareSource

Impact of Quality Metrics

By following **Practice Standards**, metric targets are met, and by meeting metric targets, we are following **Practice Standards**.

Most importantly, ***improve member outcomes***

In addition,

- Plan and Health Partner comparison for consumer reports and state report cards
- Measure improvement to quality of care
- Identify gaps in care

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Improve Quality Scores

Keep These Tips in Mind:

- ✓ Review clinical practice guidelines associated with individual patient care.
- ✓ Use the CPR within the Provider Portal.
- ✓ Ensure preventive health care screening is done within the right time frame.
- ✓ Use correct diagnosis and procedure codes.
- ✓ Ensure timely submission of claims and encounter data.
- ✓ Ensure all screenings are documented in the Medical Record and document any exclusions.

http://www.ncqa.org/

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CareSource®

What is the Access & Availability Audit?

The audit informs CareSource's ability to maintain healthcare access and availability standards for our members, fulfill network requirements, identify potential gaps and work toward their resolution

PCP & SPECIALIST APPOINTMENT AVAILABILITY
- Measures the availability to schedule an appointment when a CareSource patient calls in
- Measures urgent and emergent care

BEHAVIORAL HEALTH APPOINTMENT AVAILABILITY
- Measures the availability to schedule an appointment when a CareSource patient calls in
- Measures both prescriber and non prescriber providers
- Measures crisis protocol in urgent and emergent situations

PCP AFTER HOURS AVAILABILITY
- Measures the availability of the provider outside of normal operating hours.
- Measures live and auto attendant

Why is the Access & Availability Audit Important?

CareSource® patients rely on receiving the right care at the right time

- REGULATORY REQUIREMENTS
- IMPROVE PATIENT HEALTH OUTCOMES
- IMPROVE PATIENT EXPERIENCE & SATISFACTION
- REDUCE UNNECESSARY EMERGENCY ROOM VISITS

How Does the Access & Availability Audit Work?

DATA PROCESS

CareSource contracts a third-party vendor

CareSource sends the vendor a list of eligible providers

Quotas are set to produce a statistically valid sample

Providers are randomly selected

Auditors make up to 3 phone call attempts

Dialers use approved scripts

Results are shared with CareSource

Providers are notified

PURPOSE

Improve CareSource patients' ability to access their provider as soon as needed.

TIMING

2X/year
(Biannually)
Providers who fail have six months to improve before re-auditing

What Happens With a Failed Audit?

Providers that fail are considered non-compliant.

- Outreach from CareSource occurs
- Notification via phone call or visit from provider representative
- Review results and education on Access Standards
- Improvement plan or corrective action plan developed
- Re-audited after six months (two quarters)

Providers that pass the audit are considered compliant. No outreach will occur.

Tips to Success – Routine Care

Regular/Routine Care Appointments

Barrier/Question:	*Tips to Improve:*
The doctor in my practice has limited availability during the week (e.g., two days/week) or is unable to meet the timeframes in the standards.	It is acceptable to schedule the patient with another provider in your practice to meet the standard requirement. Set clear expectations with your patients so they are aware of the limited availability, discuss options such as seeing a partner or scheduling an appointment at different office location.
The doctor is no longer with my practice.	This is an example of the importance of having your information up-to-date to avoid unnecessary audit calls. You can update your practice information through the Provider Maintenance tab on the provider portal. Reach out to CareSource if you need assistance.
Closure during the holidays causes delays in meeting timeframes.	Standard timeframes are required even during holidays. Consider partnering with another provider office to serve as a back-up for when your office closes. Set clear expectations with your patients so they are aware of any changes in office hours & can plan appropriately.

Tips for Success – Urgent & Emergent

Urgent Care Appointments	
Barrier/Question:	*Tips to Improve:*
The practice is unable to meet the timeframes in the standards.	It is acceptable to schedule the patient with another provider or refer them to an urgent care facility
What is the definition of an urgent care visit?	An appointment for services that requires prompt attention and necessary care for unexpected illness or injury.
We have walk-in hours. Will this pass the standard?	Yes, walk-in hours are acceptable for urgent care.
What should we do to meet the standard if we are closed on Fridays?	It is acceptable to refer the patient to another provider or urgent care center and/or to transfer the patient to your triage line for same day evaluation.

Emergency Care Appointments	
Barrier/Question:	*Tips to Improve:*
My practice is unable to meet the timeframes in the standards.	It is acceptable to advise the patient to go to the nearest emergency room or to connect the patient with your triage line for immediate evaluation.
My office staff cannot advise how to treat an emergency or crisis.	Transferring the patient to clinical staff for triage is considered a passing response. This would include asking the patient to stay on the line to be connected to an on-call provider.

After-Hours Access	
• *Barrier/Question:*	*Tips to Improve:*
How did my practice fail both the live person and auto-attendant measures?	This will happen if the call is initially picked up by an auto-attendant, then service prompts to transfer to a live person. If transferred to a live person, the auditor will pursue that option. This results in both the live person and auto-attendant scripts to be followed and responses recorded for both.
Our office is small and not able to provide after-hours access to a provider.	It is acceptable to include a number to reach an on-call provider, but your practice doesn't have to be open for operation after office hours.
Why did I fail if my office has an auto-attendant in place and offers a way to reach the provider after hours as well as emergency directions?	It is possible that your recording was not working properly when the audit was conducted. Check your after-hours number to confirm it is working currently and correct the recording if there is an error. It is also possible your correct phone number was not dialed. Confirm your information is correct.

For Primary Care Providers (PCPs) only:

Provide 24-hour availability to your CareSource patients by telephone. Whether through an answering machine or taped-message used after hours, patients should be given the means to contact their PCP or back-up provider to be triaged for care. It is not acceptable to use a phone message that does not provide access to you or your back-up provider, and only recommends emergency room use for after hours.

Data Processing

Data Collection

As claims are processed, we understand more and more about our population.

Once we have collected claims and/or medical chart data, we run the data through a filtering process.

Let's take a look…

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Sharing Quality Data

The **CareSource Quality Improvement Program** provides structure and processes to ensuring member care and satisfaction.

- In place to help provide structure and key process to ensure CareSource member care and satisfaction.
- CareSource also strongly encourages you to participate in the Centers for Medicare and Medicaid Services (CMS) and Health and Human Services (HHS) quality improvement initiatives.

Quality Improvement Activities

- Provide feedback on quality improvement initiatives
- Submit quality-related data
- Fulfill medical record requests for quality improvement activities

We value your partnership in improving the health of our members.

Data Collection

First, members are identified by claims data or pharmacy data as having a condition or needing preventive care.

Meets Requirements

For this example, we will use claims and pharmacy data for diabetes.

Members who are identified by the measure are then screened for demographic requirements.

Correct Age and Gender

The member must be male or female age 18 to 75.

Passing members through these filters creates the qualifying population.

Qualifying Population

The qualifying population would be our diabetic members who meet all qualification for inclusion in the measure.

MEDICAL INSURANCE CLAIM FORM

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Data Collection

Members who qualify for a measure are screened for the care they have received.

Now that we know which members qualify, we filter out members who received the recommended care from their health partner.

Finally, we look at member health outcomes. Did the member get healthy or stay healthy?

Received Correct Care

Positive Health Outcome

Compliant Population

For this example, we would look for diabetic care recommendations: **Eye exam, A1C, BP, nephropathy**

Now, we are looking for diabetic health markers: **A1C and BP within normal limits**

Members who received all recommended care **and** displayed healthy outcomes become our compliant population.

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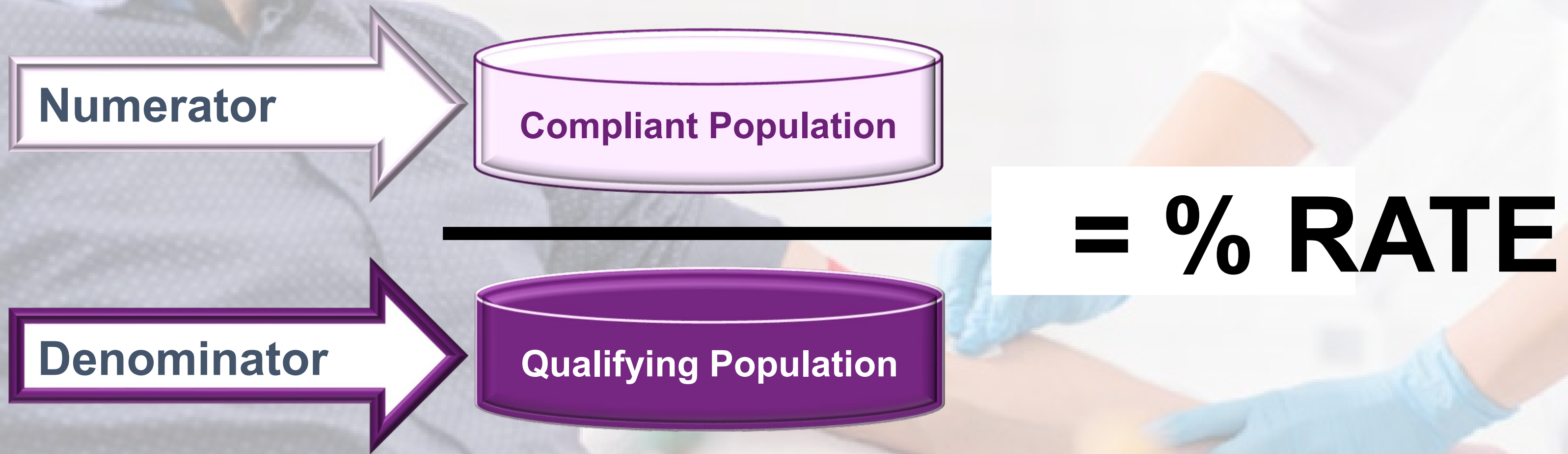
Rate Calculation



Performance Rating

Why do we rate our performance?

Metrics are used by health plans and providers to measure performance on important dimensions of care and service. Using the same metrics makes it possible to compare the performance of health plans or providers on an "apples-to-apples" basis.

CareSource also use metric results to see where we need to focus our improvement efforts.

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Available Resources

Provider: *Coding Guide*

- Intended to assist providers with
  - appropriate claims documentation for quality care associated with HEDIS measures
- These resources are available with focus on Adult, Child, and Behavioral Health Care

- Available
  - during provider onboarding
  - on CareSoure.com under plan resources
  - through our Health Partner Managers

Visit **CareSource.com** > Providers > Quick Reference Materials.

Disease Management Diabetes Program

CareSource | HEALTHMatters — Diabetes

How Yoga Can Help with Blood Sugar Management

Yoga is a popular wellness practice. It uses physical poses, breathing techniques, and meditation. Research shows that doing yoga may help:

- Reduce stress
- Boost mental well-being
- Strengthen your muscles
- Improve flexibility and balance

How Yoga Helps

Studies have shown that doing yoga may help people with diabetes manage their blood sugar levels. The studies focused on people with type 2 diabetes. Some people took a diabetes medicine called metformin. It helps control blood sugar levels. Others took metformin and began a yoga practice. Those who did yoga had greater improvements in blood sugar control than those who only took metformin.

What's the connection? The body makes hormones when you're stressed. This can raise blood sugar levels. Plus, it's harder to focus on healthy habits when you're feeling stressed. Yoga helps keep stress in check.

Getting Started with Yoga

People of all ages and abilities can do yoga. This includes older adults and people who are pregnant. If you have health issues, you may need to avoid certain poses. Talk with your primary medical provider (PMP) before beginning yoga if you have:

- Bone or joint issues
- Severe high blood pressure
- Glaucoma

continued on back

- The CareSource Disease Management Diabetes Program is designed to help our members and caregivers understand, self-manage, and increase control of their diabetes while reducing healthcare costs. The program:
- Uses industry standards and includes evidence-based resources and information.
- Collaborates with healthcare providers, specialists, and community organizations to increase awareness of health conditions and lifestyles that affect diabetes crises control, risks, and complications.
- Is integrated within the Care Management program so that the member has one point of contact for a seamless experience managing all aspects of their health.
- Provides educational materials, like condition-specific newsletters, to help members understand their condition and empower them to successfully self-manage their chronic condition.
- Covers all ages, birth through adulthood.

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MyHealth Rewards –Member Eligibility

MyHealth® Rewards in 2024:

- ❑ Members may earn up to $125
  (*Reward may vary by year and/or gender)
- ❑ Eligibility:
  - ✓Adults 18-64, automatically enrolled

2024 Rewardable Program	Frequency/ Period*	Gift Card Amount
Colorectal Cancer Screening	1x/ calendar year (per each activity)	$25
Breast Cancer Screening		$25
A1C Test for Members with Diabetes		$25
Retinal Eye Exam for Members with Diabetes		$25
Kidney Health Evaluation for Members with Diabetes (eGFR and uACR)		$25

CMS Quality Improvement Strategy in 2024 focus to improve health outcomes; reduce health & health care disparities; promote KED & offer additional Spanish literature.

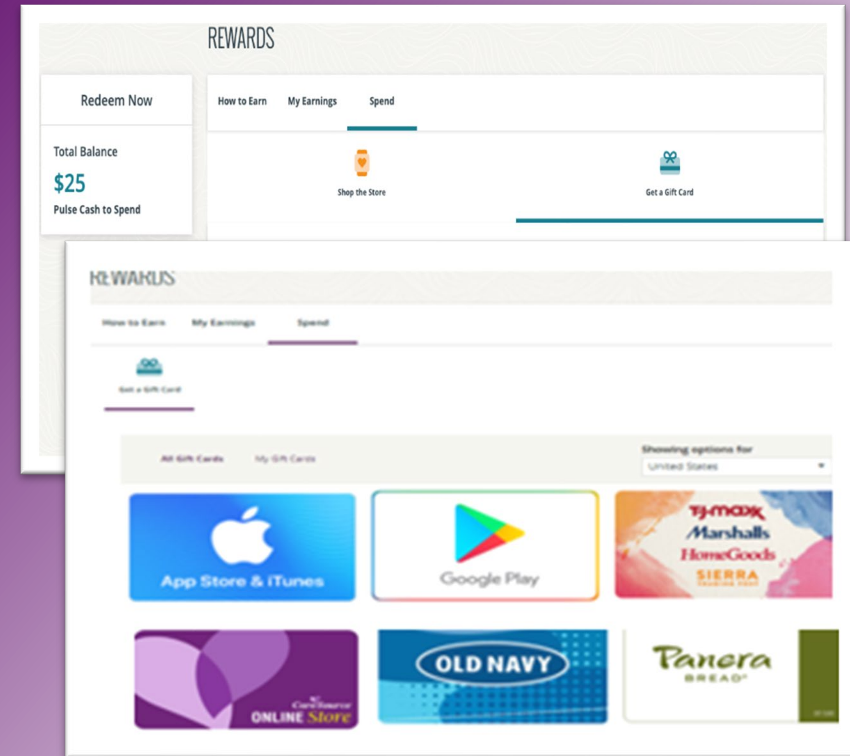
In 2024, rewards will increase for each activity i.e., KED, A1C Test, & Diabetes Retinal Eye Exam. Rewards vary by age, gender and health needs. Rewards are subject to change.

MyHealth Rewards –Member Eligibility

MyHealth® Rewards in 2024:

To earn rewards, members must:

- Complete activity.
- Provider send a claim (with a CPTII Code, when applicable).
- Once the claim is received & processed for payment, CareSource will automatically add the reward amount to the MyHealth® Rewards account.
- This process typically takes 45-60 business days from the time of completing the healthy activity.



MyHealth® Points Redemption
Members can login to their ***My CareSource*** member portal account from the ***Health*** tab to redeem points for gift cards

Diabetes Care - Provider

Provider Diabetes Reference Guide

Pocket guide & Provider Portal, Lunch & Learn

Quick Reference to Commonly Prescribed Medications for Diabetes

Combining Diabetes Agents

Quick Reference to Commonly Prescribed Medications for Diabetes

Renal dosing for glucose- lowering medications

Quick Reference to Commonly Prescribed Medications for Diabetes

The following list is intended as a general reference only and should not serve as guidelines for prescribing medications for diabetes. Please refer to the manufacturer's product information sheet or the P.D. R. for any changes in dosage schedule or contraindications.

Diabetes Reference Guide

This quick reference guide provides tips regarding Diabetes diagnosis, and pharmacotherapy information.

Screening, Diagnosis of Diabetes (Type 2) and Recommended Plan of Action

Step 1 Assess | Step 2 Initiate Plan of Action | Step 3 Follow-Up Assessment

Screening and Diagnostic Tests for Diabetes

- Support Prescribers with Diabetes Management & Pharmacotherapy with focus on improving high A1Cs
- Provider Portal and Provider guide (downloadable/printable) include:
  - ✓ List of top affordable prescribed Meds for Diabetes
  - ✓ Screening & Diagnosis of Type 2 Diabetes (adult)
  - ✓ Diagnostic Test Results & Recommended Action Plan
  - ✓ Link to CareSource Preferred Prescription Drug Formulary

Patient Care Gap reports (Clinical Practice Registry)

"High A1C", "No Result"

Link: Provider Portal _ Member Report

- CareSource Provider Portal web content:
  - ✓ Addresses clinical & data gaps for A1C, especially with "High A1C" for services already completed but we do not have the result.
  - ✓ Offers tips on how to close diabetes care gaps & a reminder that an A1C over 9% needs greater clinical attention.

Measure	Qualifying Condition and/or CPT Code	CPTII Code	Code Definition
Diabetes Measures (Comprehensive Diabetes Care)			
Diabetes A1c Control			
HbA1c	83036, 83037	3044F	HbA1c <7%
		3046F	HbA1c >9%
		3051F	HbA1c >7% and <8%
		3052F	HbA1c >8% and <9%

CareSource Provider Portal home page included:

Take Proactive Steps to Close Diabetes Care Gaps

Summary

CareSource believes that people with diabetes who are knowledgeable of their A1C results are more likely to attain A1C control. As a first step, CareSource is providing our healthcare partners with a Diabetes Care Tracking Activity to share with patients.

Background

According to the Centers for Disease Control and Prevention, nearly one in every 10 people have been diagnosed with diabetes. The prevalence of diabetes has placed an undue burden on society because of higher medical costs, lost productivity, premature mortality and intangible costs in the form of reduced quality of life. Aggressive treatment to manage A1C, blood pressure, cholesterol, and promoting tobacco cessation is key to reducing risks for diabetes-related complications. Studies have found A1C testing with a result of less than 8.0% has been linked with better management of diabetes with fewer health complications, such as heart disease, stroke and amputation. It is estimated that every percentage point drop in A1C results (i.e., from 8.0% to 7.0%) can reduce the risk of eye, kidney and nerve damage by 40 percent, as highlighted by the U.S. Department of Agriculture and Diabetes Talk.

Opportunity

CareSource educates members about the importance of talking with their health care providers about their diabetes and importance of knowing their "numbers", such as A1C test results. CareSource also supports members being referred to Diabetes Self-Management Education (DSME) Programs* by their Healthcare Providers and/or Diabetes Specialists. Click ***here*** to access ADA Recognized Education Programs.

How to Close the Care Gap

- Share the Diabetes Care Activity Tracker
- Refer the Member to DSME Programs and/or to CareSource Care Management
- Perform the recommended A1C test according to current clinical guidelines
- Document the A1C test result in the member's medical record
- Submit a claim to CareSource with the correct diagnosis and procedure codes; the CPTII codes should indicate the patient's diagnosis of diabetes **AND** the code for an A1C
- In addition, when you include the result of the A1C using the appropriate code, below, CareSource will be able to identify members who may need additional support from a CareSource case manager

There are clinical and data gaps for A1C. If you have a data gap, the service already completed, but we do not have the result. Please connect with your Health Partner to find out what you can do to close data gaps.

- **High A1C –** These patients have an A1C over 9.0% and need greater clinical attention. We defer to your process of caring for these high-risk members and your clinical expertise. Best practices include diet modification, exercise recommendations, referral to an endocrinologist or medication adjustments.
- **No Result –** We received a claim stating these patients had a test, but we do not see a result attached to that claim. Please research these for us in your lab portal or EHR (Electronic Health Record) and share the information with us via Claims, supplemental data or an email back with the results.
- **No Test –** These patients do not have a test claim. We suggest outreach to these patients to ensure they get an A1C test.

CPT II Code	Description
3044F	If HbA1c <7% documented in charts
3045F	If HbA1c between 7% - 9% documented in charts
3046F	If HbA1c is > 9% documented in charts

Depression Guide – Provider

Overview

- PCPs are treating nearly 79 percent of those being treated for depression. Some Prescribers do not feel comfortable prescribing antidepressants.
- Other roadblocks to care:
  - ✓ Shortages and limitations of access to BH Specialists
  - ✓ Stigma - Members sometimes does not feel at ease seeking treatment from BH Specialist

Provider Reference Guide – Pocket guide, Provider Portal, Email

- Support Prescribers with Depression Management and Pharmacotherapy
- Highlights reliable (lower cost) Tier 1 Generic Meds
- Reference tool includes
  - ✓ Screening and Diagnosis of Depression (Adult and pediatric, age 12+)
  - ✓ PHQ-9 Scores and Recommended Action Plan
  - ✓ Symptoms check SIG-E-CAPS to help in assessment
  - ✓ Link to FindaDoctor CareSource Provider Network Directory

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3670434/

Additional Notes

- Quick Reference also include:
  - ✓ List of top prescribed Meds for Moderate to Severe Depression
  - ✓ Link to CareSource Preferred Prescription Drug Formulary
  - ✓ Patient Resource: National Prevention Lifeline contact number/text

DEPRESSION: A Reference Guide

Side Effects for commonly prescribed anti-Depression medications:

- Headache
- Nausea
- Constipation
- Diarrhea
- Dry Mouth
- Fatigue
- Sweating
- Dizziness
- Sleep Changes
- Weight Changes (Gain & Loss)
- Fall Risk in >65 Years Old

Provider Services:

DEPRESSION: A Reference Guide

Drug Therapy | Helpful Tips & Best Practices | Tools, Information & Resources

Drug Therapy:

***Commonly Prescribed Antidepressant Medications**

Category	Drug Name Generic (Brand™)	**Cost Tier 1 or 2 Generic Medications	Indications	Starting Dose (mg)	Usual Daily Dose (mg)
SSRI	Fluoxetine (Prozac™)	$	Depression, Obsessive Compulsive Disorder (OCD)	20	20-80
SSRI	Sertraline (Zoloft™)	$	Depression, Obsessive Compulsive Disorder (OCD)	50	50 – 200
SSRI	Paroxetine (Paxil™)	$	Depression, Panic, Obsessive Compulsive Disorder (OCD)	20	20-50
SSRI	Citalopram (Celexa™)	$	Depression, Anxiety	20	10-40
SSRI	Escitalopram (Lexapro™)	$	Depression, Anxiety	10	5-20
SNRI	Venlafaxine (Effexor XR™)	$	Depression, Panic	75	75 - 350
SNRI	Desvenlafaxine (Pristiq™)	$$	Depression, Panic	150	50 - 400
SNRI	Duloxetine (Cymbalta™)	$	Depression, Anxiety, fibromyalgia, neuropathic pain	20	20 - 80
Misc.	Bupropion (Wellbutrin™ SR, XL)	$	Depression, Smoking Cessation	150	150-400
TCA	Amitriptyline (Elavil™)	$	Depression	75	40-150

*Not an exhaustive list of covered Depression medications.
The above list is intended as a general reference only and should not serve as guidelines for prescribing medications for Depression. Please refer to the manufacturer's product information sheet or the Prescription Drug Reference (PDR) for any changes in dosage or contraindications. *Brand names are registered trademarks.*
SSRI: Selective Serotonin Reuptake Inhibitors; SNRI: Serotonin and Norepinephrine reuptake inhibitors; SARI: Serotonin Antagonist and Reuptake Inhibitor; Monoamine Oxidase Inhibitors MAOIs; Tricyclic Antidepressants TCAs; Miscellaneous Misc.
**Please refer to member's current formulary for information on member specific covered medications.

Patient Health Questionnaire (PHC-9):

PHQ-9 Assessment Tool in Management of Depression

Diagnosis	None – Minimal	Mild	Moderate	Moderately Severe	Severe Depression
PHQ – 9 Score	0 - 4	5 - 9	10 - 14	15 - 19	20 - 27
Plan of Action & Follow Up Assessment	Yearly screening	Self-management support; reassess at next follow up	Assess for mania/suicide, consider pharmacotherapy, PHQ9 Monthly	Assess for mania/suicide and initiate pharmacotherapy & psychotherapy.	Assess for mania/suicide. Immediate pharmacotherapy and psychotherapy. Consider mental health specialist referral for treatment failure and severe impairment.

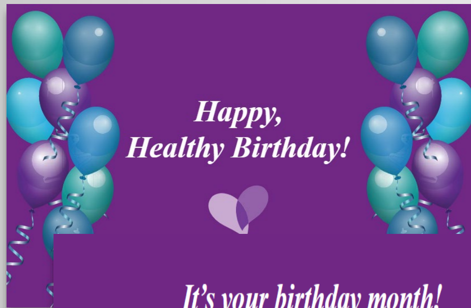
Source: Patient Health Questionnaire (PHQ) Screeners -Pfizer

Helpful Tips & Information:

- The PHQ-9 tool helps assess severity and diagnose Depression. Additionally, the HAM-D scale can be used before and during treatment. Depression and other behavioral health screening tools can be used to identify patients who would benefit from drug and/or talk therapy.
- Educate patients it may take up to 4-6 weeks to see full therapeutic and side effects.
- In elderly patients, Depression and anti-depressant therapy can increase the risk of a fall.
- Avoid duplication of therapy in patients with newly prescribed antidepressants.
- Emphasize the importance of medication adherence during the start of treatment and consider extended days supply for maintenance medications where appropriate.
- Refer patients to community and/or employer sponsored support programs where available.
- **Please note:** For moderate to severe Depression, refer to a participating (in-network) Behavioral Health (BH) Specialist (i.e., Psychiatrist/BH Clinician)

Diabetes Care – Member

Monthly Birthday Card email



It's your birthday month!

We are honored you are a CareSource member, not only on your birthday, but every day.

In order to stay healthy now and in the years to come, it is important that you do several health activities. You can learn more about the recommended health activities by going to **www.CareSource.com/birthday**. <KY MP only: You can earn a $25 reward for getting your A1C checked. It's easy! After you get your A1C test and your provider submits the claim to us, we will add the reward to your My CareSource® account under MyHealth.>

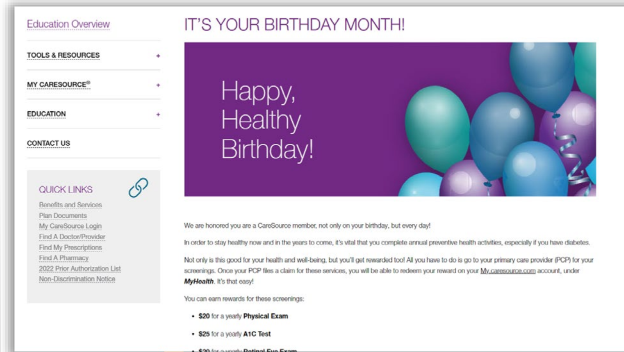
Have questions? Unsure if you need all of the suggested health activites? Call your Health Care Provider (HCP). He or she will know what is right for you based on your health history. Thank you for being a CareSource member!

Your Care Team

Diabetes Birthday Card Email

- ✓ Outreach during birthday month & wish members a Happy, Healthy Birthday
- ✓ Link to CareSource web page

"It's Your Birthday Month" web page



CareSource Member page highlights:

- ✓ The Diabetes Birthday Card
- ✓ Member Rewards
- ✓ Diabetes Activities tracker, interactive & PDF(printable)
- ✓ Link to Preventive Care Page & Chart

Diabetes Care Activity Tracker

Downloadable/printable activity tracking chart

Diabetes Care Activity Tracking Chart

If you have diabetes, use this chart to track activity goals, activity results and dates activities were completed. Just download it to a computer and use the fillable fields to enter in information. You can also print it out and take it with you to your next primary care provider (PCP) visit. If you have any questions or are not sure if you need to do all of these activities, discuss with your PCP. They will know what is right for you based on your health history.

Activity	Purpose of Activity	Frequency	Goals	Results	Date Completed
A1C*	Blood test to measure your average blood sugar (glucose) level over the past 3 months. The optimal A1C goal is 7% or less.	Each visit			
Kidney Profile*	Combo of two tests. One is the glomerular filtration rate (GFR) test. This is a blood test that checks how well your kidneys are working. The other is the albumin-creatinine ratio (ACR) test. This is a urine test that checks if you have kidney damage. Both these tests also check to see if you're at risk for developing chronic kidney disease.	Once a year			
Retinal Eye Exam*	Special eye exam that checks if your retina and blood vessels are healthy since diabetes puts you at higher risk of having eye problems.	Once every two years			
Weight/ Height	Height and weight are used to calculate your body mass index (BMI). Your PCP can then use your BMI to assess if you need to lose weight to help control your diabetes.	Each visit			
Blood Pressure	Measures the pressure of blood pushing against the walls of your arteries. Healthy blood pressure is below 120/80. Diabetes puts you at higher risk for having high blood pressure, which causes many health problems.	Each visit			

Activity	Purpose of Activity	Frequency	Goals	Results	Date Completed
Cholesterol Screening*	Measures cholesterol levels in your blood. Diabetes puts you at higher risk for having "bad" cholesterol, which can lead to heart disease.	Once a year			
Foot Inspection	Diabetic foot exam checks for numbness, tingling, pain or lack of feeling. This helps to assess nerve damage to your feet, which is often caused by diabetes.	Each visit			
Dental Exam*	A dental exam makes sure your gums and teeth are healthy. Diabetes can cause gum disease and other infections in your mouth. This is why regular dental exams are vital.	Every six months			
Stop Smoking Discussion	To let your PCP know that you wish to quit smoking. They can help you quit, and you can also call **1-800 QUIT NOW** (1-800-784-8669).	Each visit			
Vaccinations	Diabetes puts you at higher risk of developing serious health-related issues due to viruses like the flu or COVID-19. Staying up to date with vaccinations is important.	Varies by vaccine. Discuss with your PCP.			
Diabetes Self-Management Education*	To get a referral from your PCP to join a diabetes education program. These programs teach you skills to self-manage diabetes at home.	Initial and as needed			
Meet with Registered Dietitian*	To get a referral from your PCP to meet with a Registered Dietitian (RD). The RD will then start you on Medical Nutrition Therapy, which is helpful for managing diabetes.	Initial and as needed			

These services may have some exclusions. For a complete description of covered benefits please refer to your health plan benefits or call the member services phone number located on the back of your CareSource member ID card.

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It's Your Birthday Month! | CareSource

Questions?

Thank you for
caring for our members.
Qualified Health Plans offered in North Carolina by CareSource North Carolina Co., d/b/a CareSource
Multi-EXC-P-2549235