COMMUNICATING EFFECTIVELY FOR CONTINUITY OF CARE

WellCare/HealthEase/Staywell (the plan) encourages all providers—medical and behavioral—to initiate communication that facilitates and enhances continuity of care, relapse prevention, member safety and member satisfaction. Few would challenge the hypothesis that effective integration and collaboration between primary care physicians (PCPs) and mental health specialists (to include psychiatrists, social workers and ARNPs) is essential for patient well-being. Yet it is not uncommon to hear medical providers and behavioral health providers complaining they do not receive information from the opposite discipline. Barriers often cited for the dearth of provider communication are time and resource limitations. However, when one considers the potential impact on optimal member care, communication is clearly a critical necessity.

WHAT YOU CAN DO AS THE INDIVIDUAL PRACTITIONER

• Get to know your fellow physicians, PCPs and psychiatrists. Go to meetings whenever possible where you can get to know one another.
• Pick up the phone. Colleagues will appreciate the time and effort taken for communication.
• Request copies of records from physicians who have cared for the patient before your involvement.
• Set up systems in your office and hospital units that enhance and automate patient communication and permit transition of care in a safe and effective way.
• Include the PCP on admission and discharge reports, letting your colleague know about discharge appointments, medications and any specialty consultations required post-hospitalization.
• Utilize health plan Care Manager resources to assist you in making appointments and arranging follow-up care. Our staff can also work with the member to make sure he/she makes his/her appointments.

If you have questions or feedback about physician communication or quality-related topics, please contact the health plan or your local Provider Relations representative.

WEB RESOURCES

Visit www.wellcare.com to access our Preventive Health Guidelines, EPSDT documents, Pharmacy Guidelines, Cultural Competency Plan and other helpful resources. If you would like to receive a hard copy of any of these documents, please contact your Provider Relations representative.
ATTENTION DEFICIT/ HYPERACTIVITY DISORDER

WHAT IS ATTENTION DEFICIT/HYPERACTIVITY DISORDER, OR ADHD?
ADHD is a common behavioral disorder that makes it hard for a person to pay attention, sit still, and control their impulses. It can affect people in different ways. Some people may be hyperactive or have trouble being patient. ADHD can make it hard for a child to do well in school or behave at home.

There are three different types of ADHD. The most common is ADHD combined type. People who have this type have difficulty with both attention and hyperactivity. Another type is ADHD inattentive subtype, also called Attention Deficit Disorder (ADD). With this type, people have difficulty with attention and organization. The third type is called ADHD hyperactive subtype. People with this type demonstrate impulsive symptoms and hyperactivity.

WHO CAN DEVELOP ADHD AND HOW COMMON IS IT?
Children, teens and adults of all backgrounds can have ADHD. According to the National Institute of Mental Health, ADHD occurs in an estimated 3–5 percent of preschool and school-age children. Therefore, in a class of 25–30 children, it is likely that at least one student will have this condition. ADHD begins in childhood, but it often lasts into adulthood. Several studies done in recent years estimate that 30–65 percent of children with ADHD continue to have symptoms into adolescence and adulthood.¹

WHAT CAUSES ADHD?
No one knows for sure. It probably comes from a combination of things. Some possibilities are:

- Genetics and family history
- Lead in old paint and plumbing
- Smoking and drinking alcohol during pregnancy
- Certain brain injuries

WHAT ARE THE SYMPTOMS OF ADHD?
Difficulties with attention may include:

- Getting distracted easily and often forgetting things
- Switching too quickly from one activity to the next
- Having trouble focusing on one thing
- Daydreaming too much
- Having trouble finishing tasks like homework or chores
- Losing toys, books and school supplies often
- Fidgeting and squirming
- Running around
- Touching and playing with everything

Hyperactivity may include:

- Always “on the go”
- Cannot sit still
- Excessive running and climbing
- Wiggling or fidgeting

Signs of impulsivity include:

- Talking nonstop and interrupting people
- Blurtling out inappropriate comments
- Being very impatient
- Having trouble controlling emotions

What types of treatment are available for patient’s diagnosed with ADHD?

- Medications: these can be stimulants or non-stimulants. Medication may help in controlling symptoms on the day it is taken.
- Psychotherapy: therapy may help an ADHD patient learn to pay attention, to control aggressive behavior, and gain a better self-image.
- Combination of medication and psychotherapy

Source: ¹ http://www.aacap.org/cs/ADHD.ResourceCenter/adhd_faqs
EVALUATION AND MANAGEMENT CLAIMS CODING

WellCare’s Health Analytics Department, Health Services Department, and Special Investigations Unit recently completed a review of evaluation and management (E&M) coding in claims submitted to WellCare for the incurred period January 2011 through December 2011. As a result of that review, WellCare sent educational letters to physicians whose E&M services exceeded CMS-published benchmarks.

For this review, WellCare reviewed incurred claims from January 2011 through December 2011 for E&M services (new and established patient visits only) for its individual physicians in all markets. After retrieving these claims, WellCare compared, by specialty, how individual physicians’ claims matched corresponding E&M distribution data published by CMS. For the CMS distribution data, WellCare used Medicare Part B Physician/Supplier National Data Calendar Year 2009: Evaluation and Management Codes by Specialty, which can be referenced at the following link:


Next, WellCare remapped individual physician visit data to match the CMS code distributions to determine what an individual physician’s E&M cost would have been had the provider conformed to the CMS-published distributions.

WellCare recognizes that individual providers’ practices are different, and may warrant E&M coding distributions that differ from the CMS-published distribution. Please note, however, that CMS distributions already account for specialty-related variances.

As indicated, the letters were sent to physicians for educational purposes so they could review their E&M billing practices to ensure appropriate coding commensurate with the level of service and time provided for our members. Regardless of whether your practice received a letter, we ask that our providers continue to pay close attention to appropriate E&M coding. CMS has published the Evaluation and Management Services Guide as a reference for providers. It is available at:


WellCare anticipates repeating this analysis periodically and will conduct more focused audits on those providers who consistently fall in the highest range of E&M coding distribution variance.

WELLCARE MAILING ADDRESSES

Recently, we’ve noticed some claim submissions being sent to incorrect addresses. To clarify, below are our mailing addresses.

CLAIM SUBMISSIONS
Georgia and Ohio:
WellCare Health Plans, Inc.
PO Box 31224
Tampa, FL 33631-3224

All other states:
WellCare Health Plans, Inc.
PO Box 31372
Tampa, FL 33631-3372

CLAIM PAYMENT POLICY DISPUTES
WellCare Health Plans, Inc.
Payment Policy Disputes Department
PO Box 31426
Tampa, FL 33631-3426

GRIEVANCES
WellCare Health Plans, Inc.
Attn: Grievance Department
PO Box 31384
Tampa, FL 33631-3384

APPEALS (MEDICAL)
WellCare Health Plans, Inc.
Attn: Appeals Department
PO Box 31368
Tampa, FL 33631-3368
CAHPS: ASSESSING HEALTH CARE QUALITY FROM A MEMBER’S PERSPECTIVE

The Agency for Healthcare Research and Quality (AHRQ) is the leading federal agency responsible for developing standardized, evidence-based surveys and the related survey tools that are used to assess consumers’ experiences with the United States’ health care system. The Agency’s Consumer Assessment of Healthcare Providers and Systems (CAHPS®) program is the focal point of a national effort to measure, report and improve the quality of health care by utilizing respondents’ feedback about their experiences with the health care system.

While CAHPS surveys include both ratings and encounter reports, the emphasis is on the respondents’ experiences with the health care system by providing health plans, providers and facilities an analysis that is specific, actionable, understandable and objective.

The survey tools and reporting measures are standardized, which allows for valid comparisons and benchmarking across all health care settings.

Every year, WellCare works collaboratively with The Myers Group, an NCQA-Certified HEDIS® Survey Vendor, to administer the CAHPS survey to members or parents/guardians of members. The survey is used to rate their satisfaction regarding their experiences with several categories related to health care and the services provided by the health plan. Topics in the CAHPS 5.0H Survey include the following:

- Access to Getting Needed Care
- Access to Getting Care Quickly
- Patient Utilization of the Health Care System
- How Well Doctors Communicate
- Health Plan Customer Service Ratings
- Shared Decision Making
- Health Promotion and Education
- Coordination of Care
- Provider and Health Plan Ratings
- Flu/Pneumonia Vaccine
- Rating of Drug Plan
- Getting Information from Drug Plan
- Getting Needed Prescription Drugs

The CAHPS 5.0H survey results will outline what the health plan’s strengths are and identify opportunities for improvement related to these categories.

WellCare will publish highlights of our results in a future newsletter. We would like to encourage you and your staff to join our efforts to improve our member satisfaction, specifically in the areas outlined and identified as opportunities for improvement.

Sources:
1 CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ). To learn more about the CAHPS program and its products and services, visit www.cahps.ahrq.gov.
2 HEDIS® (Healthcare Effectiveness Data and Information Set) is a registered trademark of the National Committee for Quality Assurance (NCQA).
DIABETES AND EYE DISEASE: EIGHT FACTS YOUR PATIENTS NEED TO KNOW

Discussing information about diabetic eye complications and motivating your patients to engage in self-directed care may lower their risk of developing diabetes-associated vision loss. Here are some possible discussion points that you may want to share with your diabetic patients:

1. **Diabetes May Lead to Eye Disease.** Several factors influence whether patients suffer from diabetic eye disease (diabetic retinopathy, glaucoma and premature development of cataracts), including adequate blood glucose control, systemic blood pressure levels and genetic influences. Keeping blood glucose and A1C levels within a normal range may reduce their chances of developing diabetic eye disease.

2. **There May or May Not Be a Warning.** While some diabetic patients receive no warning signs of an impending catastrophic vision loss, it’s important to recognize the early warning symptoms that a significant eye disease may be developing:
   - Blurry vision
   - Double vision
   - Rings, flashing lights, or blank spots
   - Dark spots or floaters
   - Pain or pressure in the eyes
   - Trouble seeing out of the corners of their eyes

3. **Diabetic Patients Need Annual Dilated Eye Exams.** Regular eye exams by an eye care professional are important for early detection of eye disease associated with diabetes. If identified at an early stage, timely treatment and appropriate follow-up may prevent vision loss.

4. **Controlling Diabetes Won’t Prevent Diabetic Eye Disease.** Unfortunately, even if your patient’s blood glucose levels are adequately controlled, diabetic eye disease can still develop. However, successful management of a patient’s blood glucose levels may slow the onset and progression of diabetic retinopathy.

5. **Patients With Diabetes May Develop Glaucoma.** Patients with diabetes are twice as likely to develop glaucoma as people without the disease. The longer a patient has diabetes, the more common it is for glaucoma to develop.

6. **Patients With Diabetes May Develop Cataracts.** Having diabetes increases an individual’s likelihood of developing cataracts. Patients with diabetes are twice as likely to be diagnosed with cataracts at a younger age, and it progresses faster for them than it does for those individuals without the disease.

7. **Diabetic Retinopathy Damages the Retina.** Diabetic retinopathy is caused by changes in the blood vessels of the retina. When blood glucose levels remain elevated, the blood vessels that are located within the retina weaken, causing fluid to leak out of them. As this occurs, new but fragile blood vessels begin to grow (neo-vascularization). The new vessels are prone to fluid leakage, which results in the overgrowth of light-sensing retinal cells. The additional retinal cells cause damage to the retinal tissue and consequently result in vision loss and/or blindness.

8. **Laser Surgery Slows the Progression of Diabetic Eye Disease.** Laser surgery can be utilized to decrease the size of the abnormal blood vessels or seal leaking blood vessels that are located within the retina. According to the National Eye Institute, “Laser surgery has been proved to reduce the five-year risk of vision loss from advanced diabetic retinopathy by more than 90 percent.”


INCREASE YOUR PATIENT’S ADHERENCE TO PRESCRIBED TREATMENT AFTER A HEART ATTACK

One quality measure for patients’ myocardial infarction (MI) is the persistent use of beta-blockers. Evidence-based practice shows a decrease in re-infarction and mortality in heart attack sufferers when they are prescribed beta-blockers. The American Heart Association/College of Cardiology 2006 Update of Guidelines for Secondary Prevention for patients with coronary vascular disease recommends the indefinite use of beta-blockers after heart attack unless contraindicated.1

The WellCare Formulary includes the following beta-blocker drugs: acebutolol, atenolol, betaxolol, bisoprolol/hydrochlorothiazide, metoprolol, nadolol, sotalol and timolol. For a complete list, please refer to the formulary at www.wellcare.com.

The National Committee for Quality Assurance (NCQA) recommends the use of beta-blockers post myocardial infarction as one way to measure how well physicians are providing quality care to their patients with heart disease. However, despite provider education and prescriptions for the indefinite use of beta-blockers when indicated, data still shows our members have a low adherence to their treatment plan. We’d like to work with you to increase our members’ persistent use of their medications, break down barriers, and improve our patients’ outcomes.

A 2002 Vanderbilt University study determined that patients younger than 75 with a discharge order for beta-blocker therapy were more likely to fill their prescription within the first 30 days post discharge than people older than 75. Of the 85 percent that would fill their prescription within 30 days of discharge, the refill compliance would drop down to 61 percent after the first year. In contrast, of those patients discharged from the hospital without a beta-blocker, only 8 percent would fill a new prescription within the first 30 days after an acute MI2, indicating that patients who receive a prescription for beta-blockers while they are still in the acute facility have the greatest probability of continued use post discharge.

WHAT CAN YOU DO?
Start with something as simple as listening to your patients’ concerns, answering their questions and empowering them to take appropriate action. The following can serve as a guide:

• Be involved with your patients’ plan of care while they are in the hospital. Stay involved with the attending doctors to help bridge the gap in care post discharge.
• Identify the member or caretaker that may need additional educational reinforcement about the increased risk for another heart attack or stroke if they discontinue taking their medication.
• If financial constraints are an issue to their adherence, consider prescribing a generic, or utilize tablet or pill splitting when appropriate.
• Send the member a prescription refill reminder by mail or place a courtesy call.
• Address adverse effects that may be the cause for their discontinuation of the medication.

Quality improvement efforts will need to continue to be a focus so that our post-acute MI patients stay on their beta-blockers for no less than six months if indefinite therapy is not planned.

Sources:

ACCESS TO STAFF
If you have questions about the utilization management program, please call Customer Service at 1-XXX-XXX-XXXX. TTY/TDD users call 1-877-247-6272. Language services are offered.

You may also review the Utilization Management Program section of your Provider Manual. You may call to ask for materials in a different format. This includes other languages, large print and audio tapes. There is no charge for this.

TAX SEASON
Tax season is upon us again and as required, WellCare Health Plans, Inc. sent out all 1099s by January 31, 2013. If you have any questions regarding your 1099, or if you have not yet received it, please contact the dedicated service representative at 1-866-767-6066.
TAKE POSITIVE ACTION IN MANAGING MEDICATIONS

SIMPLE INTERVENTIONS PROMOTE PROPER DRUG USE, PATIENT SAFETY

WellCare/HealthEase encourages providers to make sure your patients are using the medications they need in the way they should be used. Some proactive steps you can take in this area can drive beneficial outcomes for patients.

Providers can almost instantaneously improve their patients’ health care status by systematically re-assessing the indications for and dosages of all of the medications (including herbal, over-the-counter and topical preparations) used by their patients. It’s also the perfect time to uncover the use of illicit drugs and improper consumption of alcoholic beverages.

For patients on a daily medication regimen, the use of a pill carrier – or even two if a patient is on an AM-PM dosing schedule – will help with compliance. Encouraging the use of this user-friendly tool can keep your patients on track with what medications they need to take and when to take them.

Do you ask your patients if they keep an up-to-date list of all their medications in their wallet or purse? Does the list also include their known allergies? If not, you may want to encourage them to do so.

When a patient goes to an emergency room or sees a specialist, a list of his/her current medications can keep his/her care on track, highlighting the need to treat the complete patient and potentially avoiding harmful drug-drug interactions.

For Medicare patients discharged from an acute or non-acute facility, remember that the prescribing practitioner or clinical pharmacist should reconcile the discharged medications with the most recent medication list in the patient’s medical record. This should be completed within 30 calendar days of discharge. An outpatient visit isn’t required, just documentation in the patient’s medical record that the reconciliation was conducted. Medical record documentation should include:

- Notation that medications prescribed upon discharge were reconciled with current medications by the appropriate practitioner, or
- Medications listed in the discharge summary present on the outpatient medical record and evidenced by reconciliation with current medications by the appropriate practitioner, or
- Notation that no medications were prescribed upon discharge.
2012–2013 FLU SEASON VACCINATION

If you have not already done so, WellCare is encouraging providers to ensure that each of their patients receives a flu vaccine, especially high-risk patients. Here are some important updates:

• Vaccination recommendations for adults have expanded to include all adults unless contraindicated. It is important that all people, ages 6 months and older, receive the annual influenza vaccine no matter how healthy they may be. Among older adults living outside chronic-care facilities, such as nursing homes, and for those individuals with chronic medical conditions, such as asthma, diabetes or heart disease, the flu shot has been shown to be 30–70 percent effective in preventing hospitalization stays for pneumonia and influenza. Among healthy people under age 65, the vaccine has been shown to prevent influenza outbreaks by about 70–90 percent.

• The 2012–2013 vaccines will also provide protection against:
  – A/California/7/2009 (H1N1) pdm09-like virus,
  – A/Victoria/361/2011 (H3N2)-like virus and
  – B/Wisconsin/1/2010-like virus (from the B/Yamagata line of viruses).

• WellCare offers most flu vaccinations at no cost to its members. Please encourage our members to receive the flu vaccine either in your office, at a participating retail pharmacy, or have them call the Customer Service number located on the back of their member ID card. They can also visit www.wellcare.com to locate a network provider near them.

• Antiviral drugs are especially beneficial for people who are sick with the flu. Those who may have a greater chance of serious flu complications include:
  – Children younger than 2 years old
  – Adults 65 years of age and older
  – Pregnant women and women who have given birth within the last two weeks
  – People with chronic medical conditions (such as asthma, heart failure, chronic lung disease and diabetes) and people with a weak immune system (due to illnesses such as HIV)
  – People younger than 19 years of age who are receiving long-term aspirin therapy

Source: Centers for Disease Control and Prevention; http://www.cdc.gov/flu/about/season/flu-season-2012-2013.htm#recommendations
QUALITY IMPROVEMENT AND CHART REVIEWS: THE EMR ADVANTAGE

As a health care professional, you are committed to providing high-quality care to your patients. Likewise, WellCare’s mission is to enhance our members’ health and quality of life through partnerships with providers and governments to provide quality, cost-effective health care solutions. WellCare strives to ensure our members receive the full spectrum of preventive, diagnostic and health maintenance care afforded to them under their health care benefits.

The Centers for Medicare & Medicaid Services (CMS), along with all state Medicaid agencies, have adopted NCQA’s HEDIS® (Healthcare Effectiveness Data and Information Set) metrics as the standard by which the delivery of quality care will be measured. As such, all managed Medicare and Medicaid health plans are obligated to report annually our performance against the HEDIS measures for evaluation of the quality of care our members received.

In some instances, adequate information is provided via administrative data extracted from claims submission. Yet in many circumstances, medical record review is necessary in order to capture the required data points demonstrating quality care. This creates the need to request copies of medical records and/or conduct onsite chart reviews in your office. Considering the increasing pressures on your office to maintain an efficient, often fast-paced schedule, we recognize that chart reviews and copy requests create disruption and additional expense for your practice.

Good news – there is an alternative! Did you know that you can submit electronic health records to WellCare for purposes of quality care documentation? WellCare offers our participating providers the opportunity to electronically submit the necessary data elements that will, in most cases, eliminate the need for onsite chart review or requests for copies of medical records.

According to CMS, more than $5.7 billion in electronic health record (EHR) incentive payment was made to eligible providers for their meaningful use of certified health information technology in conjunction with the American Recovery and Reinvestment Act of 2009. If you are already using EHR/EMR in your practice, we invite you to also establish a file transfer protocol with WellCare for the purpose of medical record transmission.

For more information about WellCare’s EMR protocols, please contact your Provider Relations representative or Provider Services at the phone number located on your state-specific Quick Reference Guide.
## MEDICAID 2013 Q1 PROVIDER FORMULARY UPDATE

Updates have been made to the Staywell/HealthEase Medicaid and Healthy Kids Preferred Drug List. Please visit [florida.wellcare.com/provider/pharmacy](http://florida.wellcare.com/provider/pharmacy) to view the current preferred drug list and pharmacy updates.

## MEDICARE 2013 Q1 PROVIDER FORMULARY UPDATE

Updates have been made to the Medicare Formulary. The most up-to-date complete formulary can be found at [www.wellcare.com/medicare/medication_guide](http://www.wellcare.com/medicare/medication_guide).

Please refer to your provider manual available at [www.wellcare.com/provider/ProviderManuals](http://www.wellcare.com/provider/ProviderManuals) to view more information regarding WellCare’s pharmacy utilization management policy/procedures.

### PLANNED MARKET DRUG WITHDRAWALS

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<tr>
<th>COMPANY NAME</th>
<th>DRUG NAME</th>
<th>DATE OF REMOVAL</th>
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<tbody>
<tr>
<td>Novartis Pharmaceuticals Corporation</td>
<td>Valturna® (aliskiren and valsartan) 150mg-160mg tablets, 300mg-320mg tablets</td>
<td>7/20/2012</td>
</tr>
</tbody>
</table>

**ADDITIONAL INFORMATION**

Novartis, in consultation with the FDA, has decided to voluntarily cease to market Valturna® in the US. Valturna is a single pill combination that contains aliskiren and valsartan that is only available in the US.

Patients taking Valturna should not stop their hypertension treatment without consulting their prescribing health care provider. Novartis advises patients to seek guidance from their prescribing health care provider at their next (non-urgent) visit, to determine appropriate alternate therapy.

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<tr>
<th>COMPANY NAME</th>
<th>DRUG NAME</th>
<th>DATE OF REMOVAL</th>
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<tbody>
<tr>
<td>Reckitt Benckiser Pharmaceuticals Inc.</td>
<td>Suboxone® (buprenorphine and naloxone) 2mg/0.5mg, 8mg/2mg sublingual tablets</td>
<td>9/18/2012</td>
</tr>
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**ADDITIONAL INFORMATION**

Reckitt Benckiser Pharmaceuticals Inc. confirmed that it notified the U.S. Food and Drug Administration (FDA) on September 18, 2012 that the company is voluntarily discontinuing the supply of Suboxone tablets in the US due to increasing concerns with pediatric exposure. The company received an analysis of data from U.S. Poison Control Centers on September 15, 2012 that found consistently and significantly higher rates of accidental unsupervised pediatric exposure with Suboxone tablets than seen with Suboxone film. The rates for Suboxone tablets were 7.8–8.5 times greater depending on the study period.

While the data do not isolate the root cause of these findings, the unique child resistant, unit-dose packaging of the next generation Suboxone film is believed to be one of the key contributing factors to the decrease in exposure rates compared to Suboxone tablets that are distributed in a multi-dose bottle containing 30 tablets, since the active ingredients of both products are the same. Other factors may include Reckitt Benckiser Pharmaceuticals’ community and health care professional educational initiatives in addition to the company’s Risk Evaluation and Mitigation Strategy program.

Reckitt Benckiser Pharmaceuticals is working closely with the FDA and the broader health care community to ensure patients currently taking Suboxone tablets have sufficient time and notification to appropriately transition to the same effective active ingredient with Suboxone film to minimize any risk to the continuity of their treatment. We anticipate that distribution of Suboxone tablets will be discontinued within the next six months, possibly sooner depending on discussions with the FDA.