Provider Newsletter

sunflower health plan

2023 • Issue 3

Medicaid Redetermination is Resuming This Year

TALK TO YOUR PATIENTS ABOUT CHECKING THEIR ELIGIBILITY.

This year, for the first time since 2020, about 80 million people across the country that are enrolled in Medicaid will have their eligibility redetermined, which may trigger a high risk of coverage losses. Patients may no longer be eligible due to changes in age, household income, and other state-specific criteria.

As a healthcare professional, your patients look to you for expert advice. So be sure to remind them that they are required to verify their eligibility every year or they risk losing their Medicaid coverage. Patients that are enrolled in a Dual Eligible Special Needs Plan (D-SNP), where they receive both Medicaid and Medicare benefits, must also verify their Medicaid eligibility to continue dual coverage.

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In This Issue

Sunflower Health Plan serves Medicaid members in the state of Kansas. The information presented here is also representative of our affiliated Wellcare brand of Medicare Advantage products and our Ambetter brand serving Health Insurance Marketplace members. If you have any questions, please contact Provider Engagement and Relations.

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Medicaid Redetermination is Resuming This Year *(continued)*

Let your patients know:

1. They should receive a letter a month before their Medicaid anniversary date with instructions for verifying their eligibility. They can also check renewal information online.
2. It's very important that they follow through on these instructions or they risk having their coverage canceled.
3. If they remain eligible for Medicaid, they can continue their existing coverage. If they are no longer eligible for Medicaid, they can explore Marketplace and Medicare options.

For more information about Medicaid redeterminations, please visit **medicaid.gov**.

The COVID-19 Public Health Emergency has Ended. What Does That Mean?

On May 11, 2023, the COVID-19 national emergency and public health emergency (PHE) ended.

During the PHE, emergency declarations, legislative actions by Congress, and regulatory actions across government agencies – including those by the Centers for Medicare & Medicaid Services (CMS) – allowed for changes to many aspects of health care delivery. Healthcare providers received maximum flexibility to streamline delivery and allow access to care during the PHE. While some of these changes will be permanent or extended due to Congressional action, some waivers and flexibilities will expire, as they were intended to respond to the rapidly evolving pandemic, not to permanently replace standing rules.

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The COVID-19 Public Health Emergency has Ended *(continued)*

What's Affected

- ✓ Certain Medicare and Medicaid waivers and broad flexibilities for health care providers are no longer necessary and have ended.
- ✓ Coverage for COVID-19 testing, screening and vaccination services will change to reflect members' health plan benefits.
- ✓ Providers may need to begin collecting cost shares for certain COVID-19 related services.
- ✓ Prior authorization requirements may be reinstated for certain COVID-19 related services.
- ✓ Reporting of COVID-19 laboratory results and immunization data to CDC will change.
- ✓ Certain Food and Drug Administration (FDA) COVID-19-related guidance documents for the industry that affect clinical practice and supply chains will end or be temporarily extended.
- ✓ FDA's ability to detect early shortages of critical devices related to COVID-19 will be more limited.
- ✓ The ability of health care providers to safely dispense controlled substances via telemedicine without an in-person interaction will change; however, there will be rulemaking that will propose to extend these flexibilities.

What is Not Affected

- ✓ FDA's emergency use authorizations (EUAs) for COVID-19 products (including tests, vaccines, and treatments).
- ✓ Access to COVID-19 vaccinations and certain treatments, such as Paxlovid and Lagevrio.
- ✓ Major Medicare telehealth flexibilities.
- ✓ Medicaid telehealth flexibilities.
- ✓ The process for states to begin eligibility redeterminations for Medicaid.
- ✓ Access to buprenorphine for opioid use disorder treatment in Opioid Treatment Programs (OTPs).
- ✓ Access to expanded methadone take-home doses for opioid use disorder treatment.

We are committed to providing a smooth transition for both our members and providers as we resume business as usual. While we will continue to communicate any updates to our business practices directly to our provider partners, we always highly recommend that providers verify member eligibility, benefits, and prior authorization requirements before rendering services.

References:

1. *"Fact Sheet: COVID-19 Public Health Emergency Transition Roadmap," retrieved from: https://www.hhs.gov/about/news/2023/02/09/fact-sheet-covid-19-public-health-emergency-transition-roadmap.html*
2. *"CMS Waivers, Flexibilities, and the Transition Forward from the COVID-19 Public Health Emergency," retrieved from: https://www.cms.gov/newsroom/fact-sheets/cms-waivers-flexibilities-and-transition-forward-covid-19-public-health-emergency#:~:text=Based%20on%20current%20COVID%2D19,day%20on%20May%2011%2C%202023*

Ambetter Welcomes Strong Membership Growth in 2023!

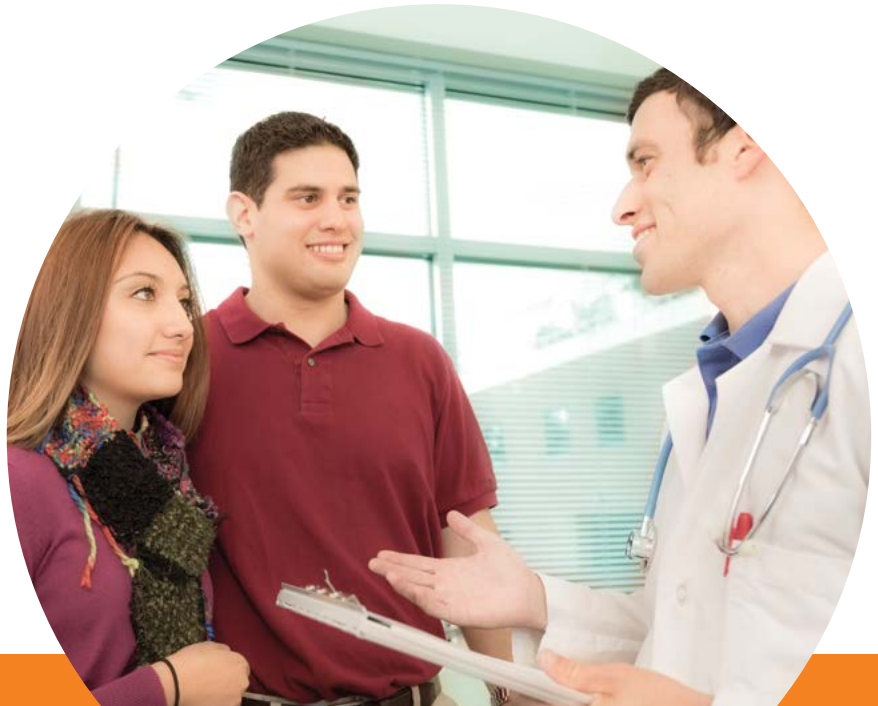
This year, Ambetter is excited to welcome quite a few new members to our Marketplace plans. As the #1 carrier on the Health Insurance Marketplace, we look forward to working with you to provide high quality care to these new members alongside our current ones.

As always, Ambetter's goal is to provide affordable care to people that need to purchase health care coverage on their own. We also seek to build strong partnerships with providers by:

Make sure to stay up to date with the latest Ambetter news and resources by visiting the Provider section of our website.

- ✓ Providing generous cost sharing to reduce patient financial responsibility while also reducing the amount providers would need to collect at time of service
- ✓ Focusing on reducing barriers and improving access to care to mitigate the risk of individuals showing up without insurance (uncompensated care)
- ✓ Encouraging members to establish relationships with PCPs to achieve favorable outcomes

**Statistical claims and the #1 Marketplace Insurance statement are in reference to national on-exchange marketplace membership and based on national Ambetter data in conjunction with findings from 2021 Rate Review data from CMS, 2021 State-Level Public Use File from CMS, state insurance regulatory filings, and public financial filings.*



Annual NCQA Accreditation Coming Soon!

We will be providing important annual information for practitioners to review regarding National Committee for Quality Assurance (NCQA) accreditation. This information will help keep practitioners informed about NCQA accreditation requirements to ensure the best care for our members. Topics include updating the provider directory, utilization management decisions, pharmacy, language services, access to case management, appointment access standards, and member rights and responsibilities, among others.

Stay tuned for more to come!

The Importance of Substance Use Disorder Treatment

According to the Substance Abuse and Mental Health Service Administration (SAMHSA), substance use disorder (SUD) treatment can help individuals' stop or reduce harmful substance misuse, improve patients' overall health, social functioning, and ways to manage risk for potential relapse. Timely intervention and treatment can increase productivity, health, and overall quality of an individual's life and have a positive economic impact, as every dollar spent on treatment saves four dollars in healthcare and seven dollars in criminal justice costs.[1]

Individuals may receive this primary SUD diagnosis in several types of settings by primary care physicians (PCP), medical specialists, and behavioral health professionals. This includes inpatient acute medical and psychiatric facilities, inpatient or outpatient withdraw management programs, emergency rooms, medical assessments conducted by a PCP or medical specialist, and outpatient mental health treatment.

One barrier to treatment is an individual's denial of their illness, particularly newly diagnosed persons with primary SUD that have long-term chronic use or dependence, as this could prevent individuals from achieving successful treatment and recovery. Whether it is a singular SUD primary diagnosis, or comorbid medical and/or mental health diagnoses, there are best practices to address barriers and improve the quality of care for at-risk member populations.

Various HEDIS® measures integrate best practice treatment recommendations for successful outcomes of individuals diagnosed with primary SUD.[2]

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The Importance of Substance Use Disorder Treatment *(continued)*

Initiation and Engagement of Substance Use Disorder Treatment (IET) Measure

Members diagnosed with a new primary SUD diagnosis occurring as part of an inpatient medical or psychiatric hospitalization, PCP visit, a medical specialist consultation, or a behavioral health evaluation are included in this measure.

SAMHSA endorses Screening, Brief Intervention, and Referral to Treatment (SBIRT) as an effective evidence-based screening tool. The SBIRT can be administered by primary care centers, hospital emergency rooms, trauma centers, and other community settings.

To improve health outcomes related to SUD treatment, once an individual 13 years and older is diagnosed, it is important to start treatment within 14 days of the primary SUD diagnosis as a best practice. Upon completion of initiating treatment, ongoing treatment can improve better outcomes by ensuring the individual has two follow-up SUD appointments within 34 days of the initial visit. Visits can occur with any practitioner with a documented diagnosis of alcohol use, opioid use, or other related substance use disorder.

Follow-Up After Emergency Department Visit for Substance Use (FUA) Measure

Individuals 13 and older admitted to an emergency department (ED) may be assessed by the ED physician, receive a medical consultation, or a behavioral health evaluation. All healthcare providers may deliver an SUD diagnosis.

Patients discharged from the ED following high-risk substance use events are particularly vulnerable to losing contact with the healthcare system. Care coordination is an important way to improve how the healthcare system works for patients, especially in terms of improved efficiency and safety.[3]

Timely follow-up within seven, but no more than 30 days, of the ED discharge are proven to improve patient outcomes. Visits can occur in various settings or via telehealth and with any practitioner for a diagnosis of SUD or drug overdose, a pharmacotherapy dispensing event, or with an approved mental health provider.

Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) Measure

Best practices for individuals 13 years and older diagnosed with SUD who are preparing for discharge from an acute inpatient medical, mental health, or substance use facility, residential treatment, or withdrawal management (detoxification) event includes a follow-up appointment within seven days after the individuals' discharge date.

Aftercare can occur with any practitioner for a principal diagnosis of SUD during an outpatient visit, telehealth visit, intensive outpatient visit, partial hospitalization, or medication assisted treatment appointments. If follow-up does not occur within seven days, it should occur no more than 30 days after discharge.

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The Importance of Substance Use Disorder Treatment *(continued)*

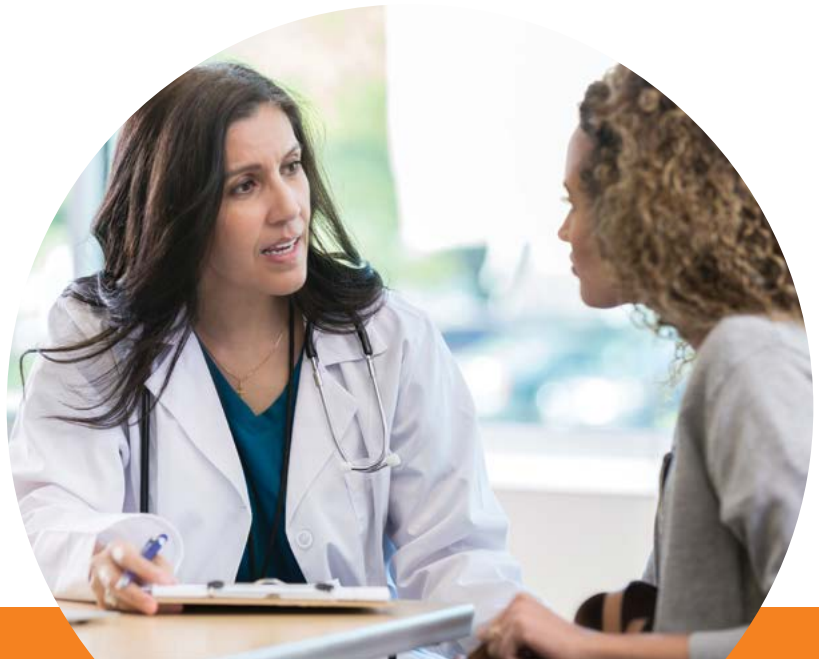
Key recommendations for successful outcomes:

- ✓ Substance use screenings and early intervention can positively affect successful outcomes.
- ✓ Engagement in treatment. Encourage your patients and their identified support to take part in treatment planning and future treatment.
- ✓ Supply available community resources and support, such as 12-step programs, peer support groups, available housing, transportation, food resources, and legal services.
- ✓ Encourage your patients' self-management of their recovery.
- ✓ Take a holistic team approach to your patients' recovery by involving family and friends along with their treating PCP, medical specialist, and behavioral health specialist to address social, medical, and/or mental health challenges individuals in recovery may face.
- ✓ Provide integrated/coordinated care between the physical and behavioral health providers to address any comorbidity.
- ✓ Provide prompt submission of claims and code substance-related diagnoses and visits correctly.
- ✓ Offer telehealth and same-day appointments.

A treatment plan that includes a prompt referral for evaluation at the time of the primary SUD diagnosis with prescribed ongoing treatment can improve the long-term health and wellness for this at-risk member population.

References:

1. *(US), Substance Abuse and Mental Health Services Administration; (US)., Office of the Surgeon General. (2016, Nov). Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Retrieved from ncbi.nlm.nih.gov: https://www.ncbi.nlm.nih.gov/books/NBK424859/*
2. *Agency for Healthcare Research and Quality. (2018, Aug). Care Coordination. Retrieved from Agency for Healthcare Research and Quality: https://www.ahrq.gov/ncepcr/care/coordination.html*
3. *National Committee for Quality Assurance. (2022). HEDIS® and performance measurement. Retrieved from NCQA.org: https://www.ncqa.org/HEDIS/*



Special Supplemental Benefits for the Chronically Ill Attestation – Important Process Change

Effective January 1, 2023, the process to determine Medicare Advantage member special supplemental benefit eligibility and chronically ill attestation requirements changed from a fax to an online system through **ssbci.rrd.com**.

Medicare members are required to schedule an office visit with their provider for evaluation. Once an appointment is made, follow these steps:

Visit **ssbci.rrd.com**.

Follow the steps on **ssbci.rrd.com** to evaluate your patient against the eligibility requirements outlined.

Submit an attestation form through **ssbci.rrd.com** indicating your patient meets the eligibility requirements.

Submit a claim containing the appropriate diagnosis codes from this office visit indicating a member has been diagnosed with one or more qualifying chronic conditions listed on **ssbci.rrd.com**.

Upon receipt of all required information, the member will be sent an **approval or denial letter within 10 business days**. Approval letters include information on steps the member should follow to activate supplemental member benefits.

2023 Partnership for Quality Provider Incentive Program Unveiled

To incentivize providers to drive care-gap closure among our Medicare Advantage members and continue the quality care they deliver. We have launched the 2023 Medicare Partnership for Quality (P4Q) Primary Care Provider Incentive Program.

Most notably, this year's program increases incentives compared to the 2022 program to better align with quality performance.

Providers can now potentially earn a 50% bonus increase by achieving an aggregate Healthcare Effectiveness Data and Information Set (HEDIS) and pharmacy star rating of 4.0 or higher across HEDIS and medication adherence measures for calendar year 2023.

Incentive payments earned through the P4Q program will be in addition to the compensation arrangement set forth in a provider's participation agreement, as well as any other incentive program in which they may participate.

To learn more or to inquire about eligibility, please reach out to your provider relations representative.

Cancer Screenings

Cervical Cancer Screening

The American College of Obstetricians and Gynecologists (ACOG) joins American Society for Colposcopy and Cervical Pathology (ASCCP) and the Society of Gynecologic Oncology (SGO) in endorsing the US Preventive Services Task Force (USPSTF) cervical cancer screening recommendations:*

- Aged less than 21 years – no screening
- Aged 21-29 years – Cytology alone every 3 years
- Aged 30-65 years – any of the following:
  - Cytology alone every 3 years
  - FDA-approved primary hrHPV testing alone every 5 years
  - Contesting (hrHPV testing and cytology) every 5 years
- Aged greater than 65 years – no screening after adequate negative prior screening results
- Hysterectomy with removal of the cervix – no screening in individuals who do not have a history of high-grade cervical precancerous lesions or cervical cancer

*These recommendations apply to individuals with a cervix that do not have any signs or symptoms of cervical cancer, regardless of their sexual history or HPV vaccination status. These recommendations **do not apply** to individuals who are at risk of the disease or those with in utero exposure to diethylstilbestrol or those who have a compromised immune system.

Source: ACOG. "Updated Cervical Cancer Screening Guidelines."
https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2021/04/updated-cervical-cancer-screening-guidelines

Screening for Breast Cancer

The American Cancer Society recommends that women undergo regular screening mammography for early detection of breast cancer. The following screening schedule is recommended for women who are not at high risk:

- Ages 40-44 should have the choice to start screening with mammograms
- Ages 45-54 – yearly mammogram
- Age 55 and older – mammogram every 2 years or may continue yearly
- Screenings should continue as long as a woman is in good health and is expected to live at least 10 additional years

Talk to your patients about the benefits of early detection of breast cancer and encourage them to take advantage of their health care coverage.

Retrieved from: American Cancer Society. "American Cancer Society Guidelines for the Early Detection of Cancer."
https://www.cancer.org/healthy/find-cancer-early/american-cancer-society-guidelines-for-the-early-detection-of-cancer.html

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Cancer Screenings *(continued)*

Prostate Cancer – Risk Factors and Screening

Prostate cancer is uncommon in men younger than age 50. The incidence rises rapidly with each subsequent decade and is higher in men with a family history of prostate cancer. African-American men are more at risk than White men and have a higher mortality rate. **Alcohol use and a diet high in saturated fats and fats of animal origin have been shown to increase risk.**

PSA testing has increased the detection rate of early-stage cancers and is of value because it is simple, objective, relatively non-invasive and low cost, however, no optimal frequency and age range for PSA and digital rectal exam have been established. A report from the European Randomized Study of Screening for Prostate Cancer (ERSPC) trial (Rotterdam – 4-year interval; Gothenburg – 2-year interval) showed that frequent screenings led to more diagnosis of cancers, but aggressive interval cancer rate was similar in the two countries.
Therefore, the data may provide a context for determining a PSA screening schedule among men who choose to be screened.

Cholesterol Education

Cardiovascular disease (CVD) is a leading cause of preventable illness, disability, and death in adults. There are social, environmental, and genetic components that all contribute to the onset of CVD. Some of these factors can be modified, treated, and controlled, while others cannot.

Non-modifiable Risk Factor	Modifiable Risk Factors	
• Age (men > age 55 & women > age 65)	• Smoking	• Poor diet
• Familial history and genetics	• Uncontrolled hypertension	• Uncontrolled diabetes mellitus
• Gender	• Uncontrolled dyslipidemia	• Stress
	• Physical inactivity	• Excessive alcohol consumption
	• Obesity and excessive weight	

As a health care provider, it is essential to properly screen and identify those patients who are at an increased risk of having CVD. This includes comprehensive health risk assessment, positive health-related behavior changes, management of lipid levels, evidence-based interventions, and patient education. To help patients control their cholesterol and decrease their risk of having a CV-related event, the Centers of Disease Control and Prevention (CDC) – Division of Heat Disease and Stroke and Prevention (DHDSP) encourages all health care providers to participate in the overall management of cardiovascular disease.

A comprehensive approach includes a cardiovascular risk assessment, patient monitoring and treatment protocols.

- **Patient-specific treatment plans should include the following components:**
  - Patient education on lifestyle modifications – the cornerstone of CVD prevention;
  - Implementation of evidence-based treatment interventions for patients with a clinical diagnosis of coronary artery disease, other atherosclerotic disease and diabetes;
  - Pharmacological treatment options for patients with elevated risk factors, including the prescription of statin drugs to lower LDLs.
- **For individuals with a clinical diagnosis of diabetes, the CDC recommends the following cholesterol levels:**
  - Total cholesterol under 200
  - LDL (“bad” cholesterol) under 100
  - HDL (“good” cholesterol) above 40 in men and above 50 in women
  - Triglycerides under 150

As a health plan, we appreciate your actions to help patients maintain a health lifestyle and reduce the incidence of cardiovascular-related diseases to improve their overall quality of life.

Continuing Opioid Therapy

Clinicians should always involve patients in decisions about whether to continue opioid therapy, along with discussion of benefits and risks:

- ✓ Expected benefits
- ✓ Common risks
- ✓ Serious risks
- ✓ Alternative options to opioids

If benefits outweigh the risks for continued therapy, work closely with the patient to optimize non-opioid therapies concurrent with opioid therapy.

If benefits do not outweigh the risks for continued therapy, optimize other therapies and work closely with the patient to gradually taper to lower doses and appropriately discontinue opioids.

For Acute pain (duration of less than 1 month):	Subacute and Chronic Pain (duration of 1-3 months and more than 3 months):
• Ensure potentially reversible causes of chronic pain are addressed • Avoid prescribing opioids "just in case" pain continues longer than expected	• Use caution when prescribing opioids at any dosage • Reassess the pain, function, and treatment course • Evaluate risks/benefits when considering dose increase • Avoid increasing dosage above levels likely to yield diminishing benefits relative to risk • Reassess and ensure potentially reversible causes of chronic pain are addressed • Establish treatment goals for new patients already receiving opioids – avoid rapid tapering or abrupt discontinuation of opioid therapy • Regularly reassess patients on long-term opioid therapy (suggested interval: 3 months)

Identify Patients Who Are at Higher Risk for Opioid Use Disorder or Overdose:

- Patients with depression or other mental health conditions
- Patients with a history of overdose
- Patients taking ≥ 50 MME/day or are taking other CNS depressants with opioids

Managing Both Long-Term Opioid Therapy and Acute Pain (for the patient who requires additional opioids for severe acute pain, e.g., postoperative):

- Only continue additional opioids for the duration that acute pain is severe enough to require them
- Return to baseline opioid dose as soon as possible
- Minimize withdrawal symptom by tapering to baseline dose if additional opioids were used continuously for more than a few days

Source: CDC. "Continuing Opioid Therapy," https://www.cdc.gov/opioids/healthcare-professionals/prescribing/continuing-opioids.html

Controlling High Blood Pressure

HYPERTENSION IS ONE OF THE KEY RISK FACTORS FOR CARDIOVASCULAR DISEASE (CVD) – INCLUDING HEART DISEASE AND STROKE.

About 1 in every 7 health care dollars is spent on heart disease.

Fast facts (US adults):

- ✓ Nearly 1 in 2 adults have hypertension
- ✓ CVD caused 1 in 3 deaths in 2019
- ✓ 23.1% of all CVD-related deaths in 2018 were from heart disease
- ✓ 5.2% of CVD-related deaths in 2019 were from stroke
- ✓ Hypertension is defined as blood pressure ≥ 130/≥ 80 mmHg, per the American College of Cardiology/American Heart Association (ACC/AHA)
- ✓ Most adults with hypertension have a blood pressure of 130/80 mmHg or higher

What Healthcare Providers Could Do to Improve Control of High Blood Pressure:

- ✓ BP checks without appointment or copayment
- ✓ Evidence-based BP treatment interventions, including:
  - Improved care coordination to help patients access and properly use anti-hypertensives and lipid-lowering prescription medications
    - Low-cost medication copayments, fixed-dose medication combinations, and extended medication fills (90-day, vs. 30-day)
    - Use of community health workers, medication management programs, and self-measured blood pressure (SMBP) monitoring with clinical support
    - Innovative pharmacy packaging (e.g., calendar blister packs)
  - Home BP monitors for patients with hypertension and reimbursement of clinicians for support services that are needed for SMBP monitoring
- ✓ Train non-medical staff to take blood pressures and help patients self-manage their BP monitoring
- ✓ Participate with community or health system pharmacies in medication therapy management programs

Source: CDC. "Control High Blood Pressure," https://www.cdc.gov/sixeighteen/bloodpressure/

Diabetes

CLINICAL GUIDELINES ON STATIN PRESCRIBING FOR DIABETIC PATIENTS AGED 40-75 YEARS

Therapy for Patients with Diabetes

The American Diabetes Association's (ADA) annual Standards of Medical Care in Diabetes has released a 2023 updated version of guidelines that includes new and updated guidance for managing patients with diabetes and prediabetes based on scientific evidence and clinical trials.

For your convenience we have provided a summary of notable changes from the Standards of Care document.

Notable 2023 Updates include:

- ✓ **Weight loss** (up to 15%) – emphasis based on newer medication availability and efficacy
- ✓ **Sleep health and physical activity** – new recommendations
- ✓ **SDOH (Social Determinants of Health)** – consideration in guiding care design and delivery
- ✓ **Hypertension** – new cut-offs (now defined as systolic ≥130 mmHg or diastolic ≥80 mmHg)
- ✓ **SGLT2 inhibitor use** – expanded role in heart failure ejection fraction
- ✓ **Finerenone** – role in diabetic individuals who also have CKD with albuminuria
- ✓ **Lipid management recommendations** – lower LDL goals for high-risk individuals

Study Excerpt:

"According to the ADA and ACC/AHA guidelines, moderate-intensity statin and lifestyle modifications are recommended for all diabetic patients aged 40–75 without contraindication to statin therapy to achieve an LDL goal of less than 100 mg/dL. Furthermore, high-intensity statin therapy is recommended for patients with cardiovascular risk factors or overt cardiovascular disease to achieve the LDL goal of less than 70 mg/day."[18,19]

"Even though statins should be prescribed for diabetic patients (> 40) regardless of their LDL laboratory values, monitoring their LDL is needed because some patients may have high LDL values even though they are using statins. It is imperative to consider this because high LDL values build up fatty deposits in the arteries, which reduce blood flow, leading to an increased risk of heart attack."[18,20]

18. *Arnett DK, Blumenthal RS, Albert MA, et al. 2019 ACC/AHA guideline on the primary prevention of cardiovascular disease: a report of the American College of Cardiology/American Heart Association Task Force on clinical practice guidelines. Circulation. 2019;140(11):e596–e646. doi:10.1161/CIR.0000000000000678*
19. *Addendum. Addendum 10. Cardiovascular disease and risk management: standards of medical care in diabetes-2021. Diabetes Care. 2021;44(9):2183–2185. doi:10.2337/dc21-ad09a*
20. *Ogasawara K, Mashiba S, Hashimoto H, et al. Low-density lipoprotein (LDL), which includes apolipoprotein A-I (apoAI-LDL) as a novel marker of coronary artery disease. Clin Chim Acta. 2008;397(1–2):42–47. doi:10.1016/j.cca.2008.07.014*

Retrieved from: Dovepress. "Adherence to Clinical Guidelines on STATIN Prescribing Among Diabetic Patients Aged 40–75 Years Old in a Primary Care Setting: A Cross-Sectional Study."

https://www.dovepress.com/adherence-to-clinical-guidelines-on-statin-prescribing-among-diabetic--peer-reviewed-fulltext-article-PPA#:~:text=According%20to%20the%20ADA%20and,less%20than%20100%20mg%2FdL.

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Diabetes *(continued)*

Other changes to the 2023 Standards of Care include:

- **Digital health, telehealth, and telemedicine** – benefits of these modalities of care delivery
- **Nonalcoholic Fatty Liver Disease (NAFLD)** – expanded subsection
- **Food insecurity** – screening by any member of the diabetes healthcare team
- **Use of technology** – in older adults
- **Use of person** – first and inclusive language
- **Vaccination** – updates for people with diabetes
- **COVID-19 and diabetes** – updates

The Standards of Care in Diabetes – 2023 is available online and is published as a supplement to the January 2023 issue of Diabetes Care.®

Retrieved from: American Diabetes Association.
Press release American Diabetes Association Releases 2023 Standards of Care in Diabetes to Guide Prevention, Diagnosis, and Treatment for People Living with Diabetes
https://diabetes.org/newsroom/press-releases/2022/american-diabetes-association-2023-standards-care-diabetes-guide-for-prevention-diagnosis-treatment-people-living-with-diabetes

Why Behavioral Health HEDIS® Matters?

Education and Resources by the Behavioral Health HEDIS Team:

The Healthcare Effectiveness Data and Information Set (HEDIS®) provides a standardized set of measures from the National Committee of Quality Assurance (NCQA) to measure clinical quality performance. HEDIS® helps Health Plans and network providers to understand the quality of care being delivered to members, identify network performance gaps, and drive the design of programs and interventions to improve quality care and outcomes.

Perinatal Depression

Perinatal depression is a mood disorder that occurs during pregnancy (called prenatal depression) and after childbirth (called postpartum depression). Symptoms include feelings of extreme sadness, anxiety, and fatigue making it difficult to carry out daily tasks, including caring for self or others.

Perinatal depression is a real medical illness that can affect any mother – regardless of age, race, income, culture, or education. It is not brought on by anything a mother has or has not done. Research suggests that perinatal depression is caused by a combination of genetic and environmental factors. Life stress, the physical and emotional demands of childbearing and caring for a new baby, and changes in hormones that occur during and after pregnancy can contribute. Women are also at greater risk for developing perinatal depression if they have a personal or family history of depression or bipolar disorder or if they have experienced perinatal depression before.

Routine pre and postnatal care can improve health outcomes and well-being for both women and their infants. The earlier depression is detected, the earlier it can be treated. The American College of Obstetricians and Gynecologists recommends **multiple postpartum visits no later than 12 weeks after birth** that include a full assessment of psychological well-being, including screening for postpartum depression and anxiety with a validated instrument.

The PHQ-2, PHQ-9, and the Edinburgh Postnatal Depression Scale (EPDS) are free, brief screening instruments. Providers should train staff on the importance of depression screenings and to recognize the risk factors for depression during and after pregnancy. Work with a care team to coordinate follow-up care for members with a positive screening, explore nonmedical treatments such as psychotherapy, acupuncture, and relaxation techniques, if appropriate. Develop a workflow that includes utilizing a standardized instrument for depression screenings at every visit and ensure all services conducted during the visit are coded appropriately, including depression screenings.

Research shows when collaboration occurs between primary, OB/GYN and behavioral health care to screen for depression, monitor symptoms, and provide or refer for treatment, patient outcomes improve.

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Why Behavioral Health HEDIS Matters?

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Federal Resources:

- Moms' Mental Health Matters (Eunice Kennedy Shriver National Institute of Child Health and Human Development, National Child & Maternal Health Education Program) **www.nichd.nih.gov/MaternalMentalHealth**
- National Institute for Mental Health: **www.nimh.nih.gov**
- Postpartum Depression (MedlinePlus, National Library of Medicine) **https://medlineplus.gov/postpartumdepression.html**
- Postpartum Support International: **www.postpartum.net**

Sources:
American College of Obstetrics and Gynecology. Screening for perinatal depression: committee opinion 757. 2018. www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Screening-for-Perinatal-Depression.
NIMH, "Postpartum depression facts;" https://www.nimh.nih.gov/health/publications/perinatal-depression/index.shtml

Follow-Up After Discharge and Coordination of Care

Our providers play a vital role in coordinating care and ensuring our members receive timely follow-up care after discharge from an emergency department (ED) or inpatient (IP) hospital stay for mental health (MH) and substance use disorder (SUD) services.

Tips for Providers to Improve Follow-Up Care:

- Partner with ED and IP facilities to provide 7-day and 30-day appointments
- Offer virtual and phone visits, if applicable
- If possible, block time on your schedule specific for urgent and follow-up visits
- Discuss the importance of attending appointments and suggest patients set up a reminder in their phone/calendar
- Send reminders to patients/caregivers ahead of the appointment
- Ask patients if they would like to bring a support person with them
- Address transportation or other barriers that may prevent the patient from attending the appointment
- Reschedule and discuss the need for additional support or resources when patients cancel or miss an appointment

Tips for Providers to Improve Coordination of Care (COC):

- Remind new patients to bring names and contact information for their other treating providers and obtain release forms
- Utilize a coordination of care checklist to document within a week of initial assessment and at least annually
- Share relevant treatment information with other treating providers after the initial assessment, start/change in medications, at discharge or transfer, and when any significant changes occur

Better management of treatment, avoidance of potential medication interactions, and quality care improves when our medical and behavioral health providers communicate and coordinate members care.

Updating Provider Directory Information

WE RELY ON OUR PROVIDER NETWORK TO ADVISE US OF DEMOGRAPHIC CHANGES SO WE CAN KEEP OUR INFORMATION CURRENT.

To ensure our members and Provider Relations staff have up-to-date provider information, please give us advance notice of changes you make to your office phone number, office address or panel status (open/closed). Thirty-day advance notice is recommended.

Thank you for helping us maintain up-to-date directory information for your practice.

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1. **You** control your banking information.
2. **No** waiting in line at the bank.
3. **No** lost, stolen, or stale-dated checks.
4. Immediate availability of funds - **no** bank holds!
5. **No** interrupting your busy schedule to deposit a check.

5 minutes to complete.

Please visit **www.payspanhealth.com/nps** or call your Provider Relations representative or PaySpan at **1-877-331-7154** with any questions. We will only deposit into your account, **not** take payments out.

Provider Formulary Updates

There have been updates to the Preferred Drug List (PDL).

Visit the plan's website to view the current PDL and pharmacy updates. You can also refer to the *Provider Manual* available on the website, and to view more information on the plan's pharmacy Utilization Management (UM) policies/procedures.

Provider Resources

Provider News – Provider Portal

Remember to check messages regularly to receive new and updated information. Access the secure portal using the Secure Login area on our home page. You will see Messages from the plan on the right side of the home page.

Remember, you can check the status of authorizations and/or submit them online. You can also chat with us online instead of calling.

Resources and Tools

You can find guidelines, key forms and other helpful resources from the homepage as well. You may request hard copies of documents by contacting your Provider Relations representative.

Refer to our *Provider Manual* and *Quick Reference Guide* for detailed information on areas including Claims, Appeals and Pharmacy. These are located at the websites listed below, under *Resources*.

- Sunflower Health Plan: **sunflowerhealthplan.com/providers.html**
- Wellcare By Allwell: **sunflowerhealthplan.com/providers/allwell-provider.html**
- Ambetter: **ambetter.sunflowerhealthplan.com**

Additional Criteria Available

Please remember that all Clinical Guidelines detailing medical necessity criteria for several medical procedures, devices and tests are available on the website, click on *Tools*.

Access to Staff

If you have questions about the utilization management program, please call Customer Service. 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. There is no charge for this.