# Provider Newsletter
Kentucky

WellCare®
Beyond Healthcare. A Better You.

2023 • Issue 3

wellcareky.com


## Medicaid Redetermination Has Resumed 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.

*(continued)*

## In This Issue



*WellCare of Kentucky, Wellcare, and Ambetter are affiliated products serving Medicaid, Medicare, and Health Insurance Marketplace members, respectively. The information presented here is representative of our network of products. If you have any questions, please contact Provider Engagement and Relations.*

WellCare Beyond Healthcare. A Better You. wellcare™ ambetter. FROM | WellCare of Kentucky

PRO_2417952E State Approved 10232023

# Medicaid Redetermination Has Resumed This Year *(continued)*

**Let your patients know:**

1. They should receive a letter a few months 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 their eligibility is confirmed, 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**.

# Cancer Screenings

## Cervical Cancer Screening

The American College of Obstetricians and Gynecologists joins the American Society for Colposcopy and Cervical Pathology and the Society of Gynecologic Oncology in endorsing the U.S. Preventive Services Task Force's current cervical cancer screening recommendations*:

- **Less than 21 years of age:** No screening.
- **Ages 21-29:** Cytology alone every three years.
- **Ages 30-65:** 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
- **Ages 65 and older:** 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*

*(continued)*

# Cancer Screenings *(continued)*

## Breast Cancer Screening

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

- **Ages 40-44:** Given choice to start screening with mammograms.
- **Ages 45-54:** Yearly mammogram.
- **Ages 55 and older:** Mammogram every two years or may continue yearly.

Screenings should continue as long as the individual is in good health and is expected to live at least 10 additional years. Talk to your patients about the benefits of early cancer detection and encourage them to take advantage of their healthcare 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*

## Prostate Cancer Risk Factors and Screening

Prostate cancer is uncommon in individuals younger than age 50. The incidence rises rapidly with each subsequent decade and is higher in individuals with a family history of prostate cancer. African Americans are more at risk and have a higher mortality rate. **Alcohol use and a diet high in saturated fats and animal fats have also 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, low-cost, and relatively non-invasive. However, no optimal frequency and age range for PSA and digital rectal exams have been established. A report from the European Randomized Study of Screening for Prostate Cancer trial (Rotterdam: four-year interval; Gothenburg: two-year interval) showed that frequent screenings led to more diagnoses of cancers, but that the aggressive interval cancer rate was similar in the two countries. Therefore, the data may provide context for determining a PSA screening schedule among individuals who choose to be screened.

# Cholesterol Education

**Cardiovascular disease (CVD) is a leading cause of preventable illness, disability, and death in adults in the United States.** 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 and sex (men over age 55 and women over age 65).<br>• Familial history and genetics. | • Tobacco use.<br>• Uncontrolled hypertension.<br>• Uncontrolled dyslipidemia.<br>• Lack of physical activity.<br>• Obesity and excessive weight. | • Poor diet.<br>• Uncontrolled diabetes.<br>• Stress.<br>• Excessive alcohol consumption. |

To help patients control their cholesterol and decrease their risk of having a CV-related event, the Centers for Disease Control and Prevention – Division for Heart Disease and Stroke Prevention encourages all healthcare providers to participate in the overall management of cardiovascular disease. Therefore, it is essential that you properly screen and identify patients who are at an increased risk of having CVD. This includes conducting comprehensive health risk assessments, promoting positive health-related behavior changes, managing lipid levels, leveraging evidence-based interventions, and supporting patient education. A comprehensive approach also includes cardiovascular risk assessments, 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 diseases, and diabetes.
- Pharmacological treatment options for patients with elevated risk factors, including the prescription of statin drugs to lower LDL.

**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.

**We appreciate your actions to help patients maintain a healthy lifestyle and reduce the incidence of CVD.**

# Continuing Opioid Therapy

**Clinicians should always involve patients in decisions about whether to continue opioid therapy, along with discussion about the expected benefits and common/serious risks of such medications.** If benefits outweigh the risks for continued therapy, work closely with the patient to talk about and optimize non-opioid therapies concurrent with opioid therapy. If benefits do not outweigh the risks for continued therapy, optimize other non-opioid therapies and work closely with the patient to gradually taper and discontinue opioids.

| For acute pain (duration of less than one month): | For subacute and chronic pain (duration of one to three months and more than three months): |
|---|---|
| • Ensure potentially reversible causes of chronic pain are addressed.<br>• Avoid prescribing opioids "just in case" pain continues longer than expected. | • Use caution when prescribing opioids at any dosage.<br>• Establish treatment goals for new patients already receiving opioids.<br>• Regularly reassess pain, function, and treatment course (suggested interval: three months).<br>• Ensure potentially reversible causes of chronic pain are addressed.<br>• Evaluate risks/benefits when considering a dose increase.<br>• Avoid increasing dosage above levels likely to yield diminishing benefits relative to risk.<br>• Avoid rapid tapering or abrupt discontinuation of opioid therapy. |

**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 patients taking other CNS depressants with opioids.

**Managing both long-term opioid therapy and acute pain (for patients who require additional opioid therapies 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," 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 one in every seven healthcare dollars is spent on heart disease.

**Fast facts (U.S. adults):**

- ✓ Nearly one in two U.S. adults has hypertension.
- ✓ CVD caused one in three 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 greater than or equal to 130/80 mmHg, per the American College of Cardiology/American Heart Association.
- ✓ Most adults with hypertension have a blood pressure reading of 130/80 mmHg or higher.

## What healthcare providers can do to improve patients' control of high blood pressure:

- ✓ Blood pressure checks without an appointment or copayment.
- ✓ Evidence-based blood pressure 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).
  - Innovative pharmacy packaging (e.g., calendar blister packs).
  - Use of community health workers, medication management programs, and self-measured blood pressure (SMBP) monitoring with clinical support.
  - Home blood pressure monitors for patients with hypertension and reimbursement of clinicians for support services that are needed for SMBP monitoring.
  - Training for non-medical staff to take blood pressures and help patients self-manage their blood pressure monitoring.
  - Participation with community or health system pharmacies in medication therapy management programs.

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

# Statin Prescribing for Diabetic Patients

**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."*

*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.*

# Therapy for Patients with Diabetes

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

**For your convenience, we have provided a summary of notable changes in the 2023 update:**

- **Weight loss (up to 15%):** Emphasis based on newer medication availability and efficacy.
- **Sleep health and physical activity:** New recommendations.
- **Social Determinants of Health:** Consideration in guiding care design and delivery.
- **Hypertension: New cutoffs** (now defined as greater than or equal to 130/80 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.

## 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:** 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.**
- **Vaccinations:** 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, diabetes.org/newsroom/press-releases/2022/american-diabetes-association-2023-standards-care-diabetes-guide-for-prevention-diagnosis-treatment-people-living-with-diabetes*

# Improving Member Experience Through Every Provider Interaction

Every one of our employees impacts the way a member experiences care. It is up to each of us to understand how we ensure that members trust us and receive high quality and patient-centered care that serves them best. Throughout the year we will focus on learning more about our member-centric culture and place members at the forefront of every decision and action we make as a health plan.

**Our member's experience is captured through the CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey that is completed yearly.** The survey for 2023 began in the beginning of March and impacts our overall Medicare Star Ratings. The CAHPS survey is helpful for us to understand how we are doing as a health plan and provides us the opportunity to notice areas of improvement. We encourage you to join us in WellCare's efforts to improve member experience and satisfaction.

**As one of our providers, you can provide a positive experience of a member's care.**

## Here are some of the best practices you can use daily to satisfy all members advise patients when additional care is needed:

- ✓ Thoroughly review charts and all documents to be able to provide the best guidance needed.
- ✓ Invite your patients to ask questions.
- ✓ Listen to patients concerns.
- ✓ Make sure you are spending enough time with each patient.

# 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 for Quality Assurance (NCQA) to measure clinical quality performance. HEDIS helps health plans and network providers 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 such as the care of one's self or others.

**Perinatal depression is a real medical illness that can affect any pregnant individual – regardless of age, race, income, culture, or education.** It is not brought on by anything the individual has or has not done. Rather, 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. Individuals 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 the well-being of both pregnant individuals and their infants. The earlier depression is detected, the earlier it can be treated. The American College of Obstetricians and Gynecologists recommends that **multiple postpartum visits occur no later than 12 weeks after birth**. These visits should include full assessments of psychological well-being, including screenings for postpartum depression and anxiety with a validated instrument such as the PHQ-2, PHQ-9, or the Edinburgh Postnatal Depression Scale (EPDS).

Providers should train staff on the importance of depression screenings and how 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 and to 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 that all services conducted during the visit are coded appropriately, including depression screenings. Research shows that patient outcomes improve when collaboration occurs between primary care providers, OB/GYNs, and behavioral healthcare professionals.

*(continued)*

**Resources:**

- Moms' Mental Health Matters (Eunice Kennedy Shriver National Institute of Child Health and Human Development, National Child & Maternal Health Education Program) **nichd.nih.gov/MaternalMentalHealth**
- National Institute for Mental Health: **nimh.nih.gov**
- Postpartum Depression (MedlinePlus, National Library of Medicine) **medlineplus.gov/postpartumdepression.html**
- Postpartum Support International: **postpartum.net**
- American College of Obstetrics and Gynecology. Screening for perinatal depression: committee opinion 757. 2018. **acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Screening-for-Perinatal-Depression**.
- NIMH, "Postpartum depression facts;" **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 that our members receive timely follow-up care after discharge from an emergency department (ED) or inpatient hospital stay for mental health and substance use disorder (SUD) services.

### Tips for providers to improve follow-up care:

- Partner with EDs and inpatient facilities to provide seven-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 keeping appointments and suggest that patients set a reminder in their phones/calendars.
- 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 patients from attending their appointments.
- Reschedule and discuss the need for additional support or resources when patients cancel or miss appointments.

### Tips for providers to improve coordination of care:

- Remind new patients to bring a list of names and contact information for their other treating providers.
- Obtain the necessary 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, whenever a medication regiment begins or changes, at discharge or transfer, and when any other significant changes occur.

**When medical and behavioral health providers communicate and coordinate member care, they can provide better treatment management, avoid potential medication interactions, and improve the quality of care.**

# Adult Immunization Status (AIS)

**Vaccines are recommended for adults to prevent severe disease, hospitalization, and death.** Specifically, the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP) advocate that adults ages 19 and older receive an annual influenza vaccine and booster doses every ten years of either tetanus and diphtheria (Td) or tetanus, diphtheria, and acellular pertussis (Tdap) vaccine.1 ACIP also recommends routine zoster vaccination for adults ages 50 and older and pneumococcal vaccination for adults ages 65 and older.

Several adults are not fully vaccinated and there is a national adult immunization plan that specifically outlines the need to prevent infections and recommend monitoring of adult vaccines.

*References:*

1. *Freedman M.S., Hunter P., Ault K., Kroger A. 2020. "Advisory Committee on Immunization Practices Recommended Immunization Schedule for Adults Aged 19 Years or Older – United States, 2020." MMWR Morb Mortal Wkly Rep 2020;69:133–135. DOI: http://dx.doi.org/10.15585/mmwr.mm6905a4.*
2. *Williams W.W., P. Lu, A. O'Halloran, et al. 2017. "Surveillance of Vaccination Coverage among Adult Populations – United States, 2015." MMWR Surveill Summ 66 (No. SS-11):1–28. DOI: http://dx.doi.org/10.15585/mmwr.ss6611a1.*
3. *U.S. Department of Health and Human Services National Vaccine Program Office. 2019. "National Adult Immunization Plan." https://www.hhs.gov/sites/default/files/nvpo/national-adult-immunization-plan/naip.pdf*

# 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.

**New Phone Number, Office Address or Change in Panel Status:**

Send an email on your letterhead with the updated information to **KY_ProviderCorrection@wellcare.com.** Please include contact information if we need to follow up with you.

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

# Electronic Funds Transfer (EFT) Through PaySpan®

**FIVE REASONS TO SIGN UP TODAY FOR EFT:**

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.

Setup is easy and takes about five minutes to complete. Please visit **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.

# Pharmacy Authorization Updates

## ALL PRIOR AUTHORIZATIONS WILL BE MANAGED BY MEDIMPACT.

Please call **1-844-336-2676** or fax all pharmacy PA requests to **1-858-357-2612**. You may also submit your request online through Cover My Meds, Surescripts, or CenterX ePA portals. For all medically billed drug (Jcode) PA requests, please continue to send those directly to WellCare for review.

**MedImpact has created an automated PA process at the pharmacy point of sale for many commonly prescribed drugs, including:**

- ✓ Anxiolytics
- ✓ Antipsychotics
- ✓ Stimulants

**Manual PA requests may be avoided if prescribers write the member's diagnosis code (ICD-10-CM format) on the face of the prescription.**

Please note prescriptions for drugs excluded from Kentucky Medicaid's Pharmacy Benefit will reject at the point of sale and prior authorization requests will be denied.

**These drugs include, but are not limited to:**

- ✓ Anorexiants (including phentermine)
- ✓ Blood and blood plasma products
- ✓ Cosmetic treatments
- ✓ Mifeprex
- ✓ Palladone
- ✓ Treatments for sexual or erectile dysfunction

To identify covered drugs, please see the Over-The-Counter (OTC) Drug List, the Preferred Drug List, and the Formulary Search tool online at **kyportal.medimpact.com**

Injectable drugs not covered under pharmacy benefit may be submitted to medical benefit for review for medical necessity.

# WellCare Office Locations

WellCare has various offices throughout Kentucky where you will find your local Provider Relations and Health Services team members.

**Louisville**
13551 Triton Park Boulevard
Suite 1200
Louisville, KY 40223-4198
Main Office Number: **1-502-253-5100**

**Lexington**
2331 Fortune Dr.
Suite 280
Lexington, KY 40509

**Hazard**
450 Village Lane
Hazard, KY 41701

**wellcareky.com/providers.html**

**Important reminder**

You can use the member's Kentucky Medicaid ID number when the WellCare member ID number is not available when billing a claim.

Please remember to use the Kentucky MMIS, **www.kymmis.com**, as your primary source of Managed Care Organization (MCO) assignment and eligibility for WellCare members. We encourage all providers to use KYMMIS as their primary source as it contains the most updated eligibility and MCO assignment information on each individual member.

# Contact Information (WellCare-Medical)

WellCare Medical PA Fax: **1-877-831-2045**

WellCare Medical PA Phone: **1-877-389-9457**

WellCare Medical PA Site: **wellcareky.com/providers/medicaid/authorizations.html**