Provider Newsletter

Wellcare Medicare

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

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Medicaid Redetermination is Resuming 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**.

The COVID-19 Public Health Emergency 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 expired, 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 Ended

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What's Affected

- ✓ Certain Medicare and Medicaid waivers and broad flexibilities for health care providers are no longer necessary and will end
- ✓ 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

Wellcare is 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*

Annual NCQA Accreditation Coming Soon!

The corporate Accreditation Network Management team 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!

Coordination of Care

HERE ARE MORE TIPS TO PROVIDE THE NEEDED CARE FOR YOUR PATIENTS:

Review medications with your patients.

Remind your patients about annual flu shots and other immunizations.

Call or contact your patients to remind them when it's time for preventive care services such as annual wellness exams, recommended cancer screenings and follow-up care for ongoing conditions such as hypertension and diabetes.

Offer to schedule specialist and lab appointments while your patients are in the office.

Make sure your patients know you also are working with specialists on their care. Ensure you receive notes from specialists about the patient's care and reach out to specialists if you have not gotten consultation notes. Tell your patient the results of all tests and procedures. Share decision making with patients to help them manage care. And please follow up on all authorizations requested for your patient.

Getting Needed Care

ACCESS TO MEDICAL CARE, INCLUDING PRIMARY CARE, SPECIALIST APPOINTMENTS AND APPOINTMENT ACCESS, ARE KEY ELEMENTS OF QUALITY CARE.

Each year, CAHPS® surveys patients and asks questions like:

- ✓ In the last 6 months, how often was it easy to get appointments with specialists?
- ✓ In the last 6 months, how often was it easy to get the care, tests, or treatments you needed through your health plan?
- ✓ In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?
- ✓ In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?
- ✓ In the last 6 months, how often did you see the doctor you were scheduled to see within 15 minutes of your appointment time?

To ensure your patients are satisfied with their ease of access:

- ✓ See members within access and availability standards
- ✓ Schedule appointments in a reasonable window for each request
- ✓ Follow up with members after referral to specialists to ensure care is coordinated
- ✓ Provide all information for specialists, tests and procedure authorizations and follow up as necessary
- ✓ Reduce time in the waiting room to no more than 15 minutes from appointment time

Remember to view the online Provider Bulletins regularly for important updates and notices. Provider bulletins are located at **www.wellcare.com**, on the Provider page for your state. Look under *News and Education* and click on *Bulletins*.

Reminder of CMS Lab Ordering Guidelines

THANK YOU FOR BEING A VALUED PARTNER AND PROVIDING QUALITY PATIENT CARE TO WELLCARE MEDICARE MEMBERS.

We understand how critical receiving timely claims payments and services are for providers to ensure the best level of care possible to our members. It has, however, been brought to our attention by our National Lab Vendors that there has been an increase in labs submitted that are not following Center for Medicare & Medicaid Services (CMS) guidelines related to services and diagnosis being populated on the order. As a result, when the Lab performs the service and submits the claim for reimbursement, these claims are being denied. This is due to the order not meeting billing criteria for reimbursement.

It is vitally important when ordering labs that you follow all **CMS Billing Guidelines**. These outline regulatory guidance as well as required information and details that ***must be included*** when ordering patient labs. This aids in timely processing and payment. Departure from these guidelines and omission of required information result in lab claims getting delayed, rejected, or denied.

The CMS Lab Billing Guidelines covers the following topics:

- ✓ Insufficient Documentation
- ✓ Documentation Requirements
- ✓ Medicare Signature Requirements
- ✓ Ordering or Referring Services

Thank you for your continued participation in our network and products. And, thank you for your partnership to resolve this urgent issue.

If you have any questions, please do not hesitate to contact your Provider Representative.

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

MEDICARE ADVANTAGE MEMBERS

To incentivize providers to drive care-gap closure among our **Medicare Advantage** members and continue the quality care they deliver, Centene has 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.

The Importance of Quality

QUALITY IS OUR PRIORITY. WE WANT OUR MEMBERS TO GET THE BEST CARE AND THE INFORMATION THEY NEED TO OPTIMIZE THEIR HEALTH.

In 2023, Wellcare will:

- ✓ Offer more, and easier, ways for our members, to complete health assessments so they can get needed care when it can do the most good.
- ✓ Continue regular review of quality outcome data to improve services and care.
- ✓ Conduct member engagement activities to gain feedback from our members on ways to better serve them.
- ✓ Continue to expand provision of high-quality customer service in different languages and easy access to TTY services for our hearing-impaired members.
- ✓ Communicate any changes to coverage of members' prescribed medications that might impact them annually so our members and their doctors can stay informed.
- ✓ Offer more ways to support the health and wellbeing of our members by increased support of our care managers and community resource workers, as well as provide support throughout an episode of care should they need an acute or emergent facility.
- ✓ Continue to improve our education and services for our members to stay in control of their chronic conditions, such as diabetes and hypertension.

To learn more about our Quality Improvement Program, please email **AccreditationMedicareOperations@Centene.com** for a copy of our Medicare Quality Improvement and Utilization Management Annual Program Evaluation, including our Special Needs Model of Care Program Evaluation, or request to become a part of the Quality Improvement and Utilization Management Committee.

Population Health and Clinical Operations (PHCO): Quality Strategy and HEDIS Operations

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.

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. *((US), Substance Abuse and Mental Health Services Administration; (US)., Office of the Surgeon General, 2016)*

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. *(National Committee for Quality Assurance, 2022)*

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Population Health and Clinical Operations (PHCO): Quality Strategy and HEDIS Operations *(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. *(Agency for Healthcare Research and Quality, 2018)*

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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Population Health and Clinical Operations (PHCO): Quality Strategy and HEDIS Operations *(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.

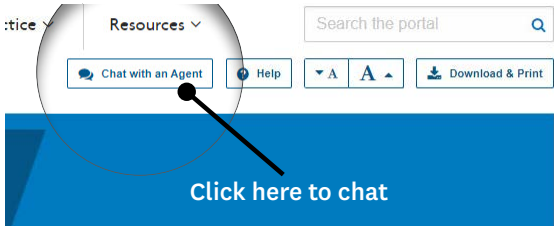
Works cited:

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/*

Providers Love Our Live Chat!

INCREASINGLY, PROVIDERS ARE CHOOSING TO CHAT WITH A LIVE AGENT ON THE PROVIDER PORTAL.

Providers are talking – about the live-chat feature on our Provider Portal, that is!



So far in 2021, live chats with our agents have increased at an unprecedented rate. As of the third quarter, more than 10 percent of our inbound interactions happened via live chat, as opposed to traditional phone calls.

That's because live chat is **the easiest and fastest way** to get access to basic status updates on a member's eligibility, claims, or authorizations. In addition, our live-chat agents are able to help with complex, on-the-spot inquiries. This means less time waiting on hold to speak to an agent on the phone. Best of all, live chat has the highest score for first contact resolution among all of our communication channels.

The next time you or someone in your office has a question, remember that **live chat is just a click away!**

Need Access?

If you'd like to learn more about the Provider Portal and its features, or would like to request access for you and your office, email **AWSEscalations@Wellcare.com**. We're here to answer any questions you have about live chat and more!

Referring Members to Behavioral Health Services

A recent Surgeon General's report estimates that up to 15 percent of the U.S. population may need behavioral health (BH) care in any given year, and that a large percentage of these individuals will go undiagnosed or undertreated.

Many individuals identify their primary care physician (PCP) as the provider they would most likely consult for a mental health problem. While many BH conditions, including depression, anxiety, and attention deficit hyperactivity disorder, can be effectively managed and treated in the primary care setting, more complicated BH conditions may require the involvement of a BH specialist.

Below are some clinical situations that might warrant BH specialist consultation:

- Your patient is having suicidal or homicidal thoughts.
- Your patient is displaying psychotic symptoms.
- Your patient has a history of multiple BH related inpatient admissions or emergency department visits.
- Your patient has received multiple BH diagnoses, or has a co-existing substance use or personality disorder.
- Your patient is unresponsive to first-line BH therapeutic interventions.

Please contact our Customer Service team at 1-855-538-0454 if you would like assistance with referring your patient to a BH provider.

Source: U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

Therapy for Patients with Diabetes

The American Diabetes Association's (ADA) annual *Standards of Medical Care in Diabetes* has released a 2022 updated version of guidelines. Based on scientific evidence and clinical trials, it includes new and updated guidance for managing patients with diabetes and prediabetes.

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

ADA Standards of Medical Care in Diabetes Guideline – 2022

Notable 2022 Updates

- ✓ Guidance on first-line therapy determined by co-morbidities includes goals to prevent complications of diabetes (such as heart or kidney disease), cost, access to care, and individual management needs.
- ✓ Prediabetes and type 2 screening should start at age 35.
- ✓ SGLT-2 inhibitors are now recommended to treat heart failure, and can be started at the time of diagnosis.
- ✓ Changes to gestational diabetes mellitus (GDM) recommendations include when to test and with whom testing should be done.

Medication Adherence:

Please use the updated guidelines information for recommendations on the diagnosis and treatment of youth and adults with type 1, type 2, or gestational diabetes. It also includes strategies for the prevention or delay of type 2 diabetes, and recommends therapeutic approaches that can reduce complications and improve health outcomes.

Reference: American Diabetes Association; Standards of Medical Care in Diabetes – 2022 Abridged for Primary Care Providers. Clin Diabetes 1 January 2022; 40 (1): 10–38. https://doi.org/10.2337/cd22-as01

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.

Resources:

1. *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*
2. *National Institute for Mental Health: nimh.nih.gov*
3. *Postpartum Depression (MedlinePlus, National Library of Medicine) medlineplus.gov/postpartumdepression.html*
4. *Postpartum Support International: postpartum.net*
5. *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*

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Why Behavioral Health HEDIS Matters? *(continued)*

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*

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 **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.

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:

Wellcare

Please call us at: 1-855-538-0454

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

Provider Formulary Updates

Medicare:

Updates have been made to the Medicare Formulary. Find the most up-to-date complete formulary at **www.wellcare.com**. Select your state from the drop-down menu and click on *Pharmacy* under Medicare in the Providers dropdown menu.

You can also refer to the Provider Manual to view more information on our pharmacy UM policies and procedures. To find your state's Provider Manual visit **www.wellcare.com**. Select your state from the drop-down menu and click on *Overview* under Medicare in the Providers drop-down menu.

Access to Staff

If you have questions about the utilization management program, please call Customer Service at **1-855-538-0454**. TTY users call **711**. 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.

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 Wellcare on the right.

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 Quick Reference Guide (QRG) for information on areas including Claims, Appeals and Pharmacy.

QRGs and Provider Manuals are located at **www.wellcare.com/providers**, click on *Resources* under your state.

Additional Criteria Available

Please remember that all Clinical Guidelines detailing medical necessity criteria for several medical procedures, devices and tests are available at **www.wellcare.com/providers**, click on *Clinical Guidelines* under your state.

MO PROVIDERS ONLY:
To add new practitioners to existing groups or to request updates or provider terminations, please email mail to:

- **CHHS_Provider_Roster@Centene.com**

Please visit **www.homestatehealth.com/providers/tools-resources.html** for roster templates.

We're Just a Phone Call or Click Away

Medicare: 1-855-538-0454

www.wellcare.com/providers