YOUR GUIDE TO PROGRAMS AND REWARDS

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Inside this Issue

Medicare Advantage Plans: A Focus on Health Equity

Our Medicare Advantage plans are working to advance health equity to improve the health and well-being of our members.

The Centers for Medicare & Medicaid Services (CMS) stresses the importance of addressing social determinants of health and providing equitable care for Medicare recipients. These goals are important to our mission, too.

Our Medicare Advantage health plans are addressing health equity by helping our members complete important preventive screenings and visits (like their Annual Wellness Visit), manage chronic diseases and overcome barriers preventing equal access to care. And we're doing it together — with the help of community resources in Tennessee and provider partners like you.

Health equity in action

Here are some of the ways we're working to address health equity for our members:

- We work with vendors and providers to offer screenings and other preventive health services at community and provider office events. Members can also complete some preventive health screenings from the comfort of their home.
- We connect members with community resources to help with things like food, transportation and housing.
- We offer programs to help address members' health needs, including behavioral health programs, at no extra cost. The programs are available online – giving members 24/7 access to these helpful resources.
- We offer telehealth services and home meal delivery after inpatient hospitalization.
- We give members access to their own care team. This team includes care management nurses, social workers, registered dietitians, health navigators and pharmacy specialists.

Extra support

We also offer extra help for members who are living with a disability, receive a low-income subsidy (LIS), and/or qualify for both Medicare and Medicaid (dual-eligible members) to help them overcome any barriers to care. And we offer additional information and support for our providers who care for these members.

CMS helps identify these high-priority members for us. But we also work to identify other members who may benefit from extra help through:

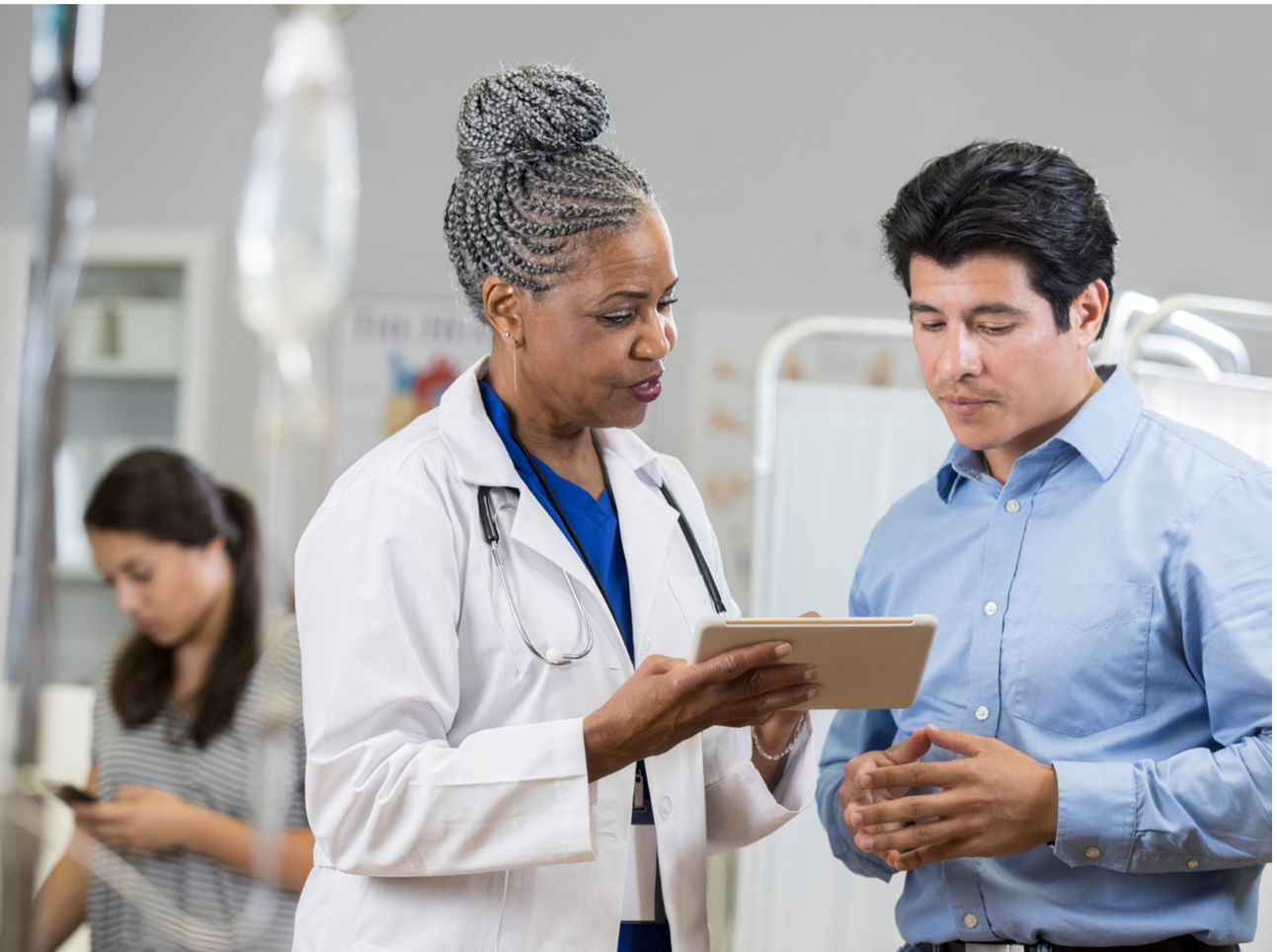
- Our annual Health Needs Assessment – followed by outreach calls to those who indicated a need for additional support.
- Calls with members. Our outreach team is trained to listen for signs a member is facing challenges in getting care.
- Risk stratification insights.
- Regular monitoring and analysis of low quality gap closure.
- Recognition of regions, counties and cities with fewer resources.
- Provider referrals. Referrals can be made to our health navigators or care management team.

A Clinical Focus

Addressing Seasonal Depression During EPSDT Visits and Other Best Practices

Winter months can often increase feelings of anxiety and depression, also known as Seasonal Affective Disorder (SAD). That's why it's important to address your BlueCare Tennessee patients' behavioral health during Early and Periodic Screening, Diagnostic and Treatment (EPSDT) visits.

EPSDT visits should include developmental and behavioral health screenings, as well as health education and anticipatory guidance for parents. These vital visit components are opportunities to discuss any areas of concern for parents and identify any behavioral health needs children may have.



Consider using these talking points to start a discussion with families about their child's overall wellness:

Emotional Health

- How well do children and teens manage and regulate their emotions?
- Do they have a positive attitude?
- Do older children and teens practice mindfulness or gratitude?

Physical Health

- Do children get regular exercise or physical activity?
- Do they make healthy food choices?
- Do families have access to nutritious food?

Social Health

- Are children aware of and interested in interacting with peers?
- Can they resolve conflict?
- Do they have age-appropriate communication skills?
- Are they empathetic towards and tolerant of others?

Spiritual health

- Are children and teens aware of and interested in their family's beliefs, values and culture?
- Do children and teens find joy in daily tasks?
- Do older children and teens practice mindfulness?

Intellectual Health

- Are children and teens interested in learning?
- Do they complete their schoolwork?
- Are they willing to try new things and discover new interests?

Occupational Health

- Are children and teens expected to perform chores and jobs in the home? If so, do they complete these tasks?
- What hobbies or interests do they enjoy?
- Are younger children interested in play and learning?
- Do children perform age-appropriate self-care tasks?

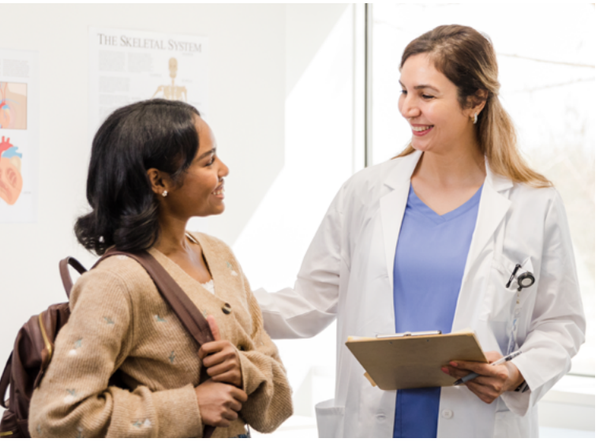
Document all seven components of EPSDT exams

When a patient visits your office for their well-child checkup, please document all seven required parts of the exam, as well as assessments of their nutrition and physical activity. Each exam should include documentation of:

- Comprehensive health (physical and mental) and developmental history
  - Initial and interval history
  - Developmental/behavioral assessment
- Comprehensive unclothed physical exam
- Vision screening
- Hearing screening
- Lab tests
- Immunizations
- Health education/anticipatory guidance

Claims submitted for EPSDT visits must match your patients' medical records and contain codes for all parts. Additionally, your patients' medical records should match the EPSDT record you send to us and include all care given during the exam.

If you're unable to complete a checkup because a patient is uncooperative, deferred or refused any part of the exam, please be sure to include this information in the patient's medical record.

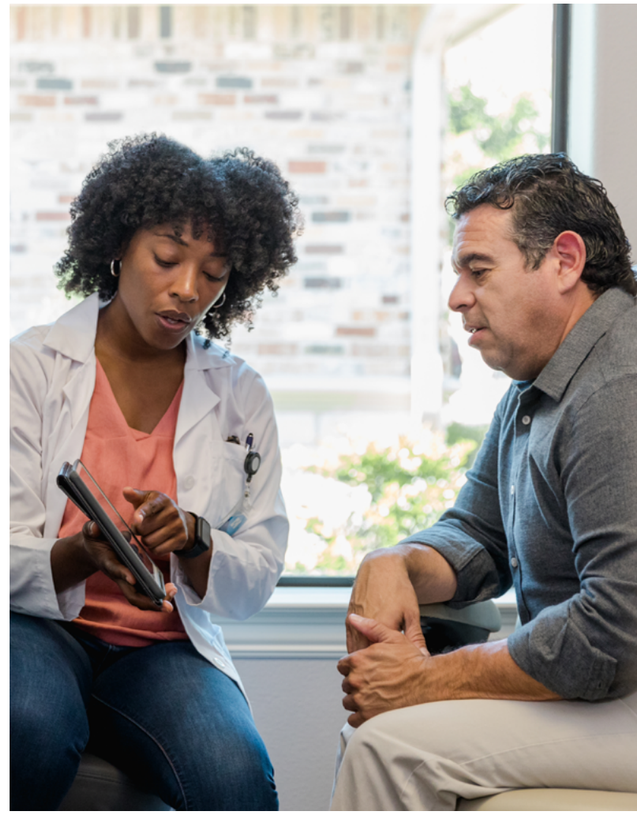


Combining a Well-Care Visit with Other Types of Visits

Many young patients go several years between checkups. This is especially true for teens and young adults. Because an office visit for an illness, shots, prescription refills or other reason may be the only chance you have to conduct a well-care check, TennCare Kids Screening Guidelines allow reimbursement for both a "sick" and "well" visit on the same day.

To learn more about combining sick and well visits, review the Tennessee Chapter of the American Academy of Pediatrics recommendations in our **EPSDT Partners in Prevention guide**.

Helping Your Patients Manage Diabetes



Diabetes is the most common chronic condition in Tennessee, and it can lead to many other long-term diseases and complications. Diabetes also has unique features that make management difficult. Diabetic patients are at risk of developing serious complications like kidney disease, visual impairment, poor wound healing, heart attack, stroke and depression.

It's important for the primary care provider to educate on the importance of proactive screening. Identifying at-risk patients early can help prevent complications. Most people don't realize elevated glucose levels are toxic to cells. Early detection of complications, regular screenings, and providing educational resources are important to help your patients manage their diabetes care and improve their quality of life.

The American Diabetes Association guidelines recommend patients adopt healthy behaviors such as regular physical activity, a balanced diet, maintaining a healthy lifestyle and completing the recommended screenings annually.

Here are some tips to keep in mind:

- Ensure treatment decisions are timely
- Rely on evidence-based guidelines
- Capture key elements within social drivers of health
- Make decisions collaboratively with patients based on their prognoses, comorbidities, informed financial considerations and preferences

HEDIS® measures for members with diabetes include:

Blood Pressure Control for Patients with Diabetes (BPD)

Patients 18-75 years old identified with diabetes (types 1 or 2) should have a controlled blood pressure of less than 140/90 as their most recent documented result during the measurement year.

Eye Exam for Patients with Diabetes (EED)

Patients 18-75 years old identified with diabetes (types 1 or 2) should have a retinal or dilated eye exam by an eye care professional or interpreted by an eye care professional during the measurement year.

Glycemic Status Assessment for Patients with Diabetes <8.0% (GSD)

Patients 18-75 years old identified with diabetes (types 1 or 2) should have their most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) reading during the measurement year documented as <8.0.

Statin Therapy for Patients with Diabetes - Received Statin Therapy (SPD)

Patients 40-75 years old identified with diabetes (types 1 or 2) that do not have clinical atherosclerotic cardiovascular disease (ASCVD) should be placed on a statin medication of any intensity during the measurement year.

Statin Adherence 80% (SPD)

Patients 40-75 years old identified with diabetes (types 1 or 2) that do not have clinical ASCVD should remain on their statin medication for at least 80% of their treatment period during the measurement year.

Kidney Health Evaluation for Patients with Diabetes (KED)

Patients 18-85 years old identified with diabetes (types 1 or 2) should have an estimated glomerular filtration rate (eGFR) AND a urine albumincreatinine ratio (uACR) during the measurement year.

Source: **Improving Care and Promoting Health in Populations: Standards of Care in Diabetes—2024 | Diabetes Care | American Diabetes Association (diabetesjournals.org)**

Promote Prenatal and Postpartum Care for Healthy Pregnancies

Prenatal and postpartum care are essential parts of improving the health of moms and babies in our state. By serving in our BlueCare℠, TennCare*Select* and CoverKids networks, providers agree to make regular and urgent prenatal appointments within these timelines:

Members in their first trimester of pregnancy

- Regular appointments: Within three weeks of the member's request
- Urgent appointments: Less than 48 hours from the date of the member's request

Members in their second and third trimesters of pregnancy

- The first prenatal appointment should occur within 15 days of Medicaid eligibility

Within 30 days of the first prenatal visit confirming pregnancy, providers caring for our BlueCare and CoverKids members should also submit a Maternity Care Notification form to let us know about the pregnancy.

HEDIS measures related to prenatal and postpartum care

The quality measure related to timely care during and after pregnancy has two components:

- The Timeliness of Prenatal Care component assesses the percentage of deliveries that received a prenatal care visit within the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization.
- The Postpartum Care component assesses the percentage of deliveries that had a postpartum visit on or between seven and 84 days after delivery.

Maternity care payments for prenatal and postpartum care

Through the BlueCare and CoverKids Maternity Care Program, OB providers can earn payments on top of their regular reimbursement for prenatal and postpartum care and mental health screening.

We've included more information about each payment below.

Prenatal care

Patients with BlueCare, TennCare*Select* or CoverKids coverage should have a prenatal visit during the first trimester of pregnancy or within 42 days of enrolling in their health plan. Providers can earn a payment of $25 per patient by completing this visit and submitting the Maternity Care Management Form in Availity® within 30 days of the prenatal visit.

Postpartum care

The postpartum visit should occur between seven and 84 days after delivery. Providers can earn $75 per patient, per claim for up to two visits during the 84-day postpartum period.

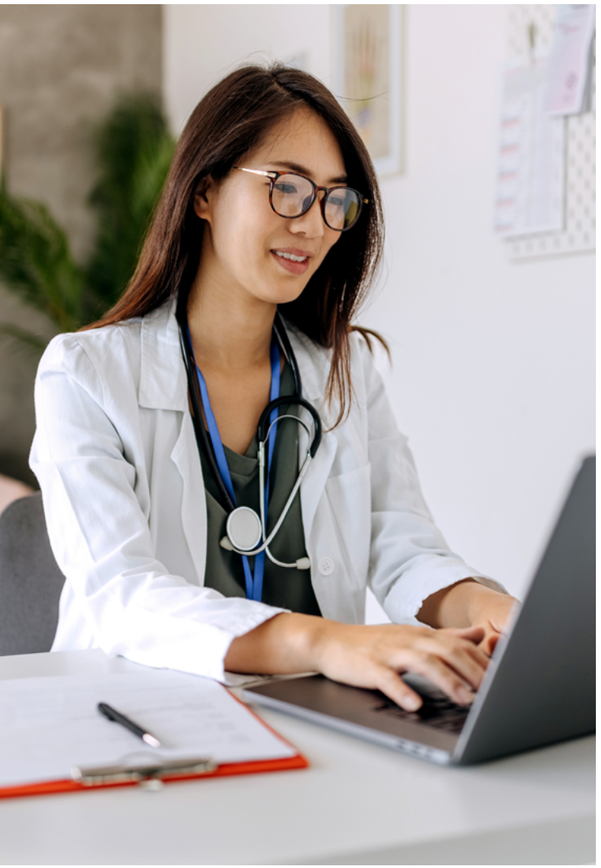
Mental health screening

Providers can earn a $28.35 payment for using a standardized tool to screen for depression and anxiety at least once during the perinatal period. There's no limit on the number of times providers can complete and bill for a mental health screening if the screening is supported by documentation.

Encourage Patients to Receive Vaccines

In addition to flu and Tdap vaccinations, patients should have a respiratory syncytial virus (RSV) vaccine between weeks 32 and 36 of pregnancy.* While this doesn't impact your quality performance, it helps safeguard infants from RSV.

* Abrysvo™ is the only RSV vaccine currently approved for use during pregnancy.



Cultural Competency Course Update – BlueCare Tennessee

Our BlueCare Tennessee network providers now have access to the full catalog of cultural competency education courses through Quality Interactions at no cost. These courses are interactive, engaging and fully mobile-friendly so you can learn on the go. Because they're accredited, you'll be eligible for one hour of Continuing Education Unit (CEU) credits upon completion.

Course types include:

- Foundational courses providing in depth information on concepts, definitions, and strategies.
- Community courses focusing on specific populations such as individuals with disabilities.
- Experiential courses are shorter case studies to help apply these concepts.

You can access the trainings at **https://learn.qualityinteractions.com/bcbstn/bluecare**.

Help Make Sure Your Patients Get the Right Care at the Right Time

Primary care providers (PCP) are an important part of helping members get the right level of care at the right time. When members go to the ER for non-emergency care, it increases strain on providers, increases care cost and can lead to poor care coordination. Many ER visits are unnecessary, and a PCP can often meet the member's care needs. Here are some ways you can help lower ER use for non-emergency care.

- Set up educational programs to be sure your patients know when to use the ER and what other options they have for non-emergency care.
- Create processes to allow for smoother care coordination between multiple providers. This can help make sure patients get the right level of care at the right time and avoid duplicate tests or treatment.
- Offer virtual care visits to provide remote care and advice.
- Implement ways to recognize and address social determinants of health. Things like housing instability, food insecurity, job-related scheduling conflicts and lack of transportation may lead to higher ER use.
- Add behavioral health care to primary care visits. This can help improve patient outcomes and increase patient satisfaction.
- Educate patients on the availability and proper use of urgent care centers. These centers can provide care for non-emergency health conditions, usually with no appointment and at a lower cost than an ER visit.
- Encourage your patients to get regular checkups and vaccines to help them stay well. Well-visits are a great time to close gaps in care for all patients, including those with long-term health conditions.
- Implement processes to be sure you're following up with patients within seven days of being discharged from the hospital or ER.

Sources

- **tcpi-changepkgmod-edvisits.pdf (cms.gov)**
- **Screening for Behavioral Health Conditions in Primary Care Settings: A Systematic Review of the Literature - PMC (nih.gov)**

Behavioral Health Transition of Care Program: Bridging the Gap for Better Outcomes

Ensuring seamless transitions of care for patients with behavioral health needs is crucial to reducing unnecessary and expensive readmissions. Our Behavioral Health Transitions of Care Program is designed to support members as they move from high readmission hospitals to outpatient care, aiming to reduce admission rates and improve overall health outcomes.

Engaging members at discharge

One of the key components of our program is engaging members at the point of discharge from high readmission hospitals. This is a critical time when patients may feel overwhelmed and uncertain about their next steps. Our team steps in to provide the necessary support and guidance, ensuring that members understand their discharge plans and are equipped with the resources they need for a successful transition.

Rounding with treatment teams

To facilitate a smooth transition, our program includes rounding with the treatment teams at the facility. This collaborative approach gives us a comprehensive understanding of each member's unique needs and treatment plans. By working closely with the hospital staff, we can ensure that all aspects of the member's care are addressed, from medication management to follow-up appointments. This collaboration helps to create a cohesive care plan that supports the member's recovery and reduces the risk of readmission.

Collaboration with outpatient providers and Tennessee Health Links

After discharge, our program continues to support members by collaborating with outpatient Tennessee Health Links (THLs). These liaisons play a vital role in bridging the gap between inpatient and outpatient care. They work closely with members to coordinate follow-up care, connect them with community resources, and provide ongoing support. This continuity of care is essential for maintaining the progress made during the inpatient stay and preventing setbacks that could lead to readmission.

Comprehensive support for better outcomes

Our Behavioral Health Transitions of Care Program is built on the principles of collaboration, communication and continuity. By engaging members at discharge, rounding with treatment teams, and collaborating with outpatient THLs, we create a robust support system that addresses the multifaceted needs of our members. This helps reduce readmission rates and empowers members to take an active role in their recovery.

We're dedicated to ensuring members receive the care and support they need during one of the most vulnerable times in their healthcare journey. By focusing on seamless transitions and ongoing support, we strive to improve health outcomes and enhance the quality of life for our members.

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