Health Alliance™

February Informed Newsletter

February 18, 2025

Endless Thanks

As another new year moves forward, with spring already in our sights, we want to extend our gratitude to you, your staff and all your colleagues for all that you do for our members. We know their health is in great hands because of your expertise. We're fortunate to have you as a partner, as together we bring wellness to everyone who counts on us. Today – and every day – we offer our deepest, heartfelt thanks.

Stelara Formulary Removal

Effective April 1, 2025, Stelara® (ustekinumab) will be a nonformulary medication, and all non-Medicare patients will need to switch to an ustekinumab biosimilar for covered treatment. Several biosimilars have been approved by the Food and Drug Administration (FDA) over the last several months and will become available in the coming weeks. Per the FDA, these products have no clinically meaningful differences and share the same indications as Stelara. Several products will have interchangeability designations as well. We expect many of these biosimilars to have manufacturer copay cards, which may lower the monthly cost for eligible patients.

To better facilitate this transition, no new prior authorizations will be needed to switch products as long as the patient has been filling Stelara consistently or has an active prior authorization on file. Patients and prescribers impacted will be receiving individualized letters notifying them of this change. At this time, one ustekinumab biosimilar, Wezlana™, has been added to the formulary at the preferred specialty tier. As more biosimilars become available, more products will be added at parity.

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Help us move the needle.

Together we can help people live their healthiest lives. Find reminders, tips and more in this section, to guide improvements in patient outcomes. Help us move the needle.

Closing Gaps in Care

It's hard to believe we're already in the second month of 2025. In this early part of the year, it's important to make sure your patients are getting the appropriate preventive services they need to identify any issues and close any gaps in their care. As appropriate, please remind your patients about the following screenings, visits and services.

All Patients:

- Annual Wellness Visit.
- Medication review.
- Blood pressure reading.
- Colorectal cancer screening.
- Statins therapy for patients with clinical atherosclerosis.
- Seasonal flu vaccine.

Women:

- Breast cancer screening.
- Cervical cancer screening.
- Osteoporosis screening for women who've had a fracture.

- Prenatal and postpartum care for pregnant women.

Patients with Diabetes:

- A1C test.
- Nephropathy screening.
- Diabetic retinal eye exams.

Patients with Rheumatoid Arthritis:

- Treatment with a disease-modifying antirheumatic drug (DMARD).

Also, please remember we have health coaching and care coordination services that can help our members manage their conditions at no extra cost to them. We know you worry about your patients' health between visits, and these services can help improve their outcomes throughout the entire year.

Make sure your patients get their flu shots.

We're still in the midst of flu season, so make sure you're reminding your patients to get their yearly flu vaccine. Your voice is key. According to the CDC, recommendations – and even simple reminders – from their trusted providers are a critical factor in whether many adults get vaccines for themselves and their families. Most of them know vaccines are important, but they need reminders from you to take action and actually get the shot. And make sure to follow up with them – during each subsequent visit, check to see if they've gotten the vaccine yet. If not, repeat your recommendation and address any questions or concerns they might have.

With all this in mind, the CDC is continuing its vital SHARE campaign – meant to help providers do all they can to encourage their patients to get their yearly flu shot. Here are the basics, quoted from their campaign:

- **S – Share** the reasons why an influenza vaccine is right for the patient given their age, health status, lifestyle, occupation or other risk factors.
- **H – Highlight** positive experiences with influenza vaccines (personal or in your practice), as appropriate, to reinforce the benefits and strengthen confidence in influenza vaccination.

- **A – Address** patient questions and any concerns about influenza vaccines, including side effects, safety and vaccine effectiveness, in plain and understandable language. Acknowledge that while people who get an influenza vaccine may still get sick, there are studies that show that illness may be less severe.
- **R – Remind** patients that influenza vaccines help protect them and their loved ones from serious influenza illness and complications that can result in hospitalization or even death for some people.
- **E – Explain** the potential costs of getting influenza, including potential serious health effects for the patient, time lost (such as missing work or family obligations), financial costs and potentially spreading influenza to more vulnerable family or friends.

Each patient is different, and you know them best. Consider the best approach that'll let them know just how important the flu vaccine is and why they and their families should get it. With your help, our communities can stay safer – and breathe easier – through this year's flu season. Thanks for your assistance in this vital endeavor.

It varies according to health plan, but flu shots are covered at no cost to our members in most cases. Your patients can call the number on their health plan member ID card to learn more about costs and where they can go to get their shots.

HEDIS Chart Reviews for 2025 (Measurement Year 2024)

We collect data to determine how we measure up against national averages for HEDIS®* (the Healthcare Effectiveness Data and Information Set). This data collection and analysis is required for National Committee for Quality Assurance (NCQA) accreditation, and it indicates where we need to focus our quality efforts to better serve our members and provider partners.

Help us get the documentation we need to show HEDIS quality-measure performance:

- We collaborate with your office staff to obtain necessary documentation. Most provider offices and organizations allow us access to their electronic medical record (EMR).

- If you don't have an EMR, we can conduct a site visit to get the information or we can fax a request to you.

We're currently in the midst of our HEDIS data collection season, which began this month and ends in May. Thank you for your cooperation during this important season of measurement.

If you have any questions about HEDIS, or are interested in setting up remote access, contact our Quality Management department at (217) 902-9354 or (800) 851-3379, Ext. 9354.

**The Healthcare Effectiveness Data and Information Set (HEDIS®) is a set of quality standards that helps us together measure and assess the care and treatments patients receive. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).*

A Care Team Approach to Blood Pressure Management

We know how busy you are as providers, and how helpful it can be when other members of your team – or other healthcare professionals out in the community – work with you to provide care for your patients. The CDC calls this "team-based care," where health professionals from different disciplines work collaboratively alongside the patient to give them the care and services they need. **Here are some tips from the CDC for providing team-based care for your patients' blood pressure management.**

- Under the direction of the patient's primary care provider, **strategically assign and share responsibilities** for the patient's blood pressure management plan.
- **Remember that the patient is part of the "team" too** – give them self-management duties like tracking their blood pressure at home, adhering to their medications, etc.
- **Assign a team member to be responsible for patient follow-up.** This person (or persons) should support patients between their office visits, regularly communicating with them to check up on the patient's self-management and adherence, and to schedule and confirm upcoming appointments.
- Since maintaining a healthy blood pressure often requires finding the appropriate medications and adjusting the dosages to discover

the best fit, **assign qualified team members (perhaps even a pharmacist) to manage the patient's medications**.

- **Social workers or other team members can help with adherence support.** Patients might skip medications because they can't afford them, or they might miss doctor visits because they lack transportation. A dedicated team member can help them find resources to overcome these barriers.
- **Health coaches, dietitians and others can help patients with lifestyle changes.** Through education, coaching and behavior counseling, patients can learn to eat healthier, increase their physical activity, reduce their stress, stop smoking and more.

Prenatal and Postpartum Care: HEDIS Measures

By meeting HEDIS®* quality measures, we together improve care for your patients. Here are some important quality measures for prenatal and postpartum care.

What Is Measured

- **The timeliness of prenatal care:** HEDIS measures the **percentage of pregnant women who had a prenatal care visit in the first trimester**, on or before their enrollment start date with their health plan, or within 42 days of enrollment.
- **Postpartum care:** HEDIS measures the **percentage of women who had a postpartum visit anytime seven to 84 days after giving birth**.

Why It Matters – and Recommendations

These HEDIS measures are important because both prenatal and postpartum care are vital to the health of both mother and baby. Every year, about 1 million U.S. women have complications during their pregnancy. That's about 25% of all who give birth. And studies have shown that perhaps 60% of pregnancy-related deaths could be prevented if women had better access to care, received higher-quality care, and made lifestyle and health changes as recommended by their providers.

Timely and high-quality prenatal and postpartum care is key:

- Joint guidelines from the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists (ACOG) recommend a prenatal visit in the first trimester for all women.
- ACOG also recommends that all women have contact with their OB-GYN within three weeks after birth, followed by ongoing care as needed, and concluding with a comprehensive postpartum visit no later than 12 weeks after giving birth.

Thank you for your continued dedication to your patients' health.

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Our Diabetes Meal Benefit

If your patient has diabetes and is a member of one of our health plans, they might have access to no-cost, home-delivered meals that'll help them control their A1C. Here are the details:

- They'll get 90 days of meals delivered right to their door from GA Foods® (a shipment of 14 meals every week, for 14 weeks), at no cost to them.
- They simply heat the meals in their microwave or oven.
- All meals are low in salt, sugar, fat and cholesterol.

We make it easy for them. They'll appreciate the convenience and benefits of home-delivered meals:

- No need to shop or prepare meals.
- All meals are suitable for people with diabetes managing their blood glucose levels.
- Chefs add flavor and flair to traditional favorites that they'll love.
- These home-delivered consistent-carb meals help keep their blood sugar at normal ranges.

We look forward to helping your patients control their A1C.

Note: Not all of our plans offer this benefit, so your patients should call the number on their health plan member ID card to ask if their plan includes this.

Chlamydia Screening Recommendations

Please use this table, directly from the CDC.

Chlamydia – Screening Recommendations and Considerations Referenced in Treatment Guidelines and Original Sources	
Women	• Sexually active women under 25 years of age. • Sexually active women 25 years of age and older if at increased risk. • Retest approximately three months after treatment. • Rectal chlamydial testing can be considered in females based on reported sexual behaviors and exposure, through shared clinical decision between the patient and the provider.
Pregnant Women	• All pregnant women under 25 years of age. • Pregnant women 25 years of age and older if at increased risk. • Retest during the third trimester for women under 25 years of age or at risk. • Pregnant women with chlamydial infection should have a test of cure four weeks after treatment and be retested within three months.
Men Who Have Sex with Women	• There is insufficient evidence for screening among heterosexual men who are at low risk for infection, however, screening young men can be considered in high prevalence clinical settings (adolescent clinics, correctional facilities, STI/sexual health clinic).
Men Who Have Sex with Men (MSM)	• At least annually for sexually active MSM at sites of contact (urethra, rectum) regardless of condom use. • Every three to six months if at increased risk (i.e., MSM on PrEP, with HIV infection, or if they or their sex partners have multiple partners).
Transgender and Gender-Diverse Persons	• Screening recommendations should be adapted based on anatomy (i.e., annual, routine screening for chlamydia in cisgender women < 25 years old should be extended to all transgender men and gender-diverse people with a cervix; if over 25 years old, persons with a cervix should be screened if at increased risk).

	• Consider screening at the rectal site based on reported sexual behaviors and exposure
Persons with HIV	• For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter. • More frequent screening might be appropriate depending on individual risk behaviors and the local epidemiology.

Metabolic Monitoring for Children and Adolescents on Antipsychotic Medications

If you have a young patient (child or adolescent) currently on antipsychotic medication, make sure you regularly perform metabolic monitoring (blood glucose and cholesterol testing). Here's what you need to know, from the experts at the National Committee for Quality Assurance and Tony Cohn, MD, writing in Psychiatric Times.

In recent years, an increasing number of children and adolescents have been prescribed antipsychotics. These drugs can raise their risk of developing serious metabolic health issues, some with possible lifelong consequences. **It's therefore very important to regularly perform metabolic monitoring.**

- Conduct baseline monitoring when an antipsychotic drug is first prescribed – and when patients are switched onto an antipsychotic with high metabolic liability, like clozapine or olanzapine.
- Three months after this initial baseline testing, monitor again. This is highly valuable in assessing any early metabolic changes.
- Young patients who've never previously had antipsychotic medications are particularly susceptible to fast weight gain.
- Common early metabolic changes include an increase in triglyceride levels and changes in body weight. Initially, fasting glucose and hemoglobin A1C levels generally stay low.
- Acute onset of diabetes can occasionally be picked up at the three-month point – this is a clear indication to discontinue or switch the antipsychotic medication.

In general, the goals of metabolic monitoring are:

- Early detection of treatable metabolic conditions like diabetes, dyslipidemia and hypertension.

- Identification of patients at heightened risk for metabolic disorder (prediabetes, severe obesity, metabolic syndrome), in order to begin prevention and health promotion efforts.
- The assessment and evaluation of metabolic interventions like antipsychotic switching, pharmacotherapy and psychotherapy.

Metabolic Monitoring Parameters

Based on American Diabetes Association/American Psychiatric Association Consensus Guidelines, Sourced Directly from Tony Cohn, MD, "Metabolic Monitoring for Patients on Antipsychotic Medications," Psychiatric Times, Vol. 30 No. 12, 20 December 2013

	Baseline	Week 4	Week 8	Week 12	Every Three Months Thereafter	Annually
Medical History*	X			X		X
Weight (BMI)	X	X	X	X	X	X
Waist Circumference	X			X		X
Blood Pressure	X			X		X
Fasting Glucose/Hemoglobin A	X			X		X
Fasting Lipids	X			X		X

**Personal and Family History of Obesity, Diabetes, Hypertension and Cardiovascular Disease*

2025 CAHPS Survey (Medicare Patients)

The Medicare Consumer Assessment of Healthcare Providers and Systems® (CAHPS) is an annual survey that gathers feedback from Medicare beneficiaries about their experiences with health insurance and drug coverage plans, as well as with the broader healthcare system. We use CAHPS feedback to identify areas where patient experience can be enhanced, and we then partner with you and other providers to implement targeted improvements.

2025 CAHPS Survey Timeline: February 26 – May 31.

Learn how you can help us and your patients – and simply read more about what CAHPS is – by using these quick resources we've created for you:

- **CAHPS Tool Kit.**
- **CAHPS PowerPoint.**

Thank you for your dedication to improving healthcare quality.

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Coding Counts: Specificity Matters

Supporting documentation and accurate coding are key to making sure your patients receive the care they need. Failure to document chronic conditions on an annual basis impacts your patients, fellow providers and our organization. **Here is why specificity in documentation and coding are so important.**

Specificity in diagnosis coding and documentation:

- Results in fewer claim denials and audit findings.
- Positively impacts research and treatment for diseases when studied by the CDC's National Center for Health Statistics (NCHS).
- Determines whether certain conditions are an HCC (a Hierarchical Condition Category).
- Influences a patient's ability to receive all eligible benefits and services from their health plan, such as care coordination and health coaching.

Helpful Tip:
Make sure that your diagnosis code and documentation match. For example, if you reported CKD III, then documentation should state CKD III rather than CKD unspecified. For further understanding of the impact from an HCC perspective, please reference the CKD (chronic kidney disease) HCC hierarchy.

HCC	Disease
NA	Chronic Kidney Disease Unspecified
NA	Chronic Kidney Disease I
NA	Chronic Kidney Disease II
329	Chronic Kidney Disease III Unspecified, Stage III A
328	Chronic Kidney Disease III B
327	Chronic Kidney Disease IV
326	Chronic Kidney Disease V or End-State Renal Failure
NA	Acute Renal Failure
RXHCC261	Renal Dialysis

We thank you for your attention to detail and professionalism, and we're always here to help. To find more coding resources and information, visit our

Coding Counts page. Thank you for your continued care and dedication to our members' health.

Questions?

Please contact us at CodingCounts@HealthAlliance.org.

References Used for this Article:
EncoderPro.com for Payers

Contact Us

(800) 851-3379, Option 3