

# Anthem<sup>®</sup>



## Medicaid Updates

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- Website address for latest updates <https://providers.anthem.com/ohio-provider/home>
- Website address for provider manuals, policies and forms <https://providers.anthem.com/ohio-provider/home>
- Online training opportunities **Training opportunities, such as Provider Orientation, Connections App, Availity and more can be found on our provider website, <https://providers.anthem.com/ohio-provider/home>**
- How to locate a provider representative **Provider Representative Territory Map is located here: [https://providers.anthem.com/docs/gpp/OH\\_CAID\\_ProvExpTerritoryMap.pdf](https://providers.anthem.com/docs/gpp/OH_CAID_ProvExpTerritoryMap.pdf)**
- Upcoming medical policy changes/policy review **None at this time, however any medical policy changes will be communicated in our monthly provider newsletter, as well as on our provider website. To sign up for provider communications, please visit [providernews.anthem.com/ohio](http://providernews.anthem.com/ohio) and hit 'subscribe to email' to register.**
- Effective 6/1/2023, Anthem Medicaid implemented the Floor to SNF program to assist in members being transferred to participating SNFs in a timely fashion. For more information on this program, please see this communication: <https://providernews.anthem.com/ohio/articles/floor-to-snf-for-in-network-skilled-nursing-facilities>
- What are the main new types of value based contracting are you engaging in – specific specialties?
  - **PQIP (total cost of care MLR based program for primary care providers)**
  - **PQIP ESN (pay for performance program for primary care providers)**
  - **Negotiated Risk and Shared Savings (total cost of care MLR based program for primary care providers – evolution of PQIP)**
  - **OBQIP – (incentive program for OB providers based on quality, improvement, and utilization)**
  - **SDOHPIP – (Incentive for completing the PRAPARE tool or ACES survey, referring members to community resources, etc. Available to providers of any specialty)**
  - **BHQIP – (Incentive for eligible BH providers such as community mental health centers (CMHCs), community services boards (CSBs) and local mental health authorities (LMHAs) based on quality, improvement, and utilization)**
- Do you participate with the state's HIE, Clinisync, and if so what way are you partnering with them and providers on HIE? **This information can be found in our provider manual at [https://providers.anthem.com/docs/gpp/OH\\_CAID\\_ProviderManual.pdf?v=202306052027](https://providers.anthem.com/docs/gpp/OH_CAID_ProviderManual.pdf?v=202306052027)**

## Quality Programs/Initiatives

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### *Quality Withhold:*

- **Pregnancy Risk Assessment Form (PRAF)-** Provider Assistance- Currently we are partnering with our 40 different providers to understand how best we can meet their needs. There are 3 different interventions that we are testing once outreach is established: Billing review, Provider toolkit, Gap reports, and lastly Quality enhancer. The provider toolkit is multifaceted user manual that steps through the processes of gaining access the Nurture

website for Pregnancy Risk Assessment Forms (PRAF) all way to how to complete the billing aspect of the PRAF. Each practice that we are partnering with we are getting a Voice of the Provider to understand their current process and needs to decide which intervention to lead with. The Quality Enhancer is a stipend on the current payment for the PRAF submission to encourage engagement from providers. Member Assistance – Member incentives are a key to connecting members to care across all seven Managed Care Plans (MCPs). We have partnered with Queens Village that gave our African American mother’s a gift for completing their prenatal visit and the provider submitting a PRAF. This has led the MCPs to develop a way for the member to have access at their fingertips with a creation of a website and being piloted now. This website is for all members, and all the resource information provided leads each member to their individual MCP to get connected to care by Find a Provider or their CareGuide team. Along with needed access to care, the MCPs offer value-added benefits (VABs) such as baby essentials and more critical resources that fall under the Social Determinants of Health (SDoH) category from transportation to food and/or utilities and houses resources. This is really the idea of “everything under one roof” for our members, with added provider resources is later iterations and development. Please reach out to [karam.johnson@anthem.com](mailto:karam.johnson@anthem.com) if you need any provider resources and want to partner or have questions on what is offered to our members.

- **Diabetes-** Continuous Glucose Monitoring and Diabetes Self-Management Education- Currently we are testing the Diabetes Provider Toolkit with practices, along with the other Medicaid MCPs, to gain insight and feedback on its content from staff involved within the CGM prescribing and DSME referral to appointment follow-through processes. The purpose and intent of this toolkit is to eliminate administrative barriers to prescribing CGM and/or referring to DSME, increasing the utilization of services, and improving the overall health of the diabetic Medicaid member population in Ohio. In the future, plans intend to house this content on a website that will be updated on a regular basis to give our health care provider partners a “one stop shop” resource for diabetes management. Please reach out to [nora.trimboli@anthem.com](mailto:nora.trimboli@anthem.com) if your practice is interested in being a part of this project.
- Additionally, if practices are interested in getting CGM samples into their office, more information on PulseWrx Phones for their members with CGMs, transportation concerns, ConferMed e-consult services, or have questions regarding DSME, I would be happy to provide further information.

### ***Internal Improvement Initiatives***

- **Metabolic Monitoring for Children/Adolescents (1-17) on Antipsychotic Medications-** Partnering with ODM and the other Ohio Medicaid MCPs on a performance improvement project to increase metabolic monitoring (blood glucose/A1c, LDL) for children/adolescents on antipsychotic medications. Additionally, working internally to pinpoint areas in where the Health Plan can support providers in increasing rates of metabolic testing and increasing member overall awareness of the importance, especially amongst children and adolescents within the foster care system. This initiative will also look at atypical prescribing and use of first-line psychosocial care. We are looking for Pediatric BH practice partnerships to assist us in these efforts, as insight from subject matter experts will be imperative. Please reach out to [nora.trimboli@anthem.com](mailto:nora.trimboli@anthem.com) if you are interested in collaborating with our team on this project.
- **Follow-Up Hospitalization 7-Days Post-Discharge for Mental Illness-** Anthem is looking to partner with practices to increase follow-up hospitalization 7-days post discharge for mental illness. We would love to learn more about successes and barriers within these practices to identify potential areas where health plans may be able to provide additional support. If you are interested in collaborating on this project, please reach out to [nora.trimboli@anthem.com](mailto:nora.trimboli@anthem.com).

- **SBIRT and ACEs Training-** Are there practices interested in learning more about Screening, Brief Intervention, and Referral to Treatment or Adverse Childhood Experiences trainings. We may be providing these in the near future. Please reach out to [nora.trimboli@anthem.com](mailto:nora.trimboli@anthem.com) to express your interest in participating.
- **Comprehensive Diabetes Care: Controlling Blood Pressure-** Anthem is looking to partner with practices that may be interested in a potential pilot collaboration with GA Foods. This program would involve a practice identifying members of their diabetic/hypertensive patient population that would be willing to participate, and follow through with, a program aimed at providing meals, regular monitoring of vitals, and nutritional education and support over a pre-determined number of weeks. Meals will start as pre-made, but following nutritional education and guidance, they will slowly change over to grocery boxes while learning about recipes appropriate to their chronic condition and healthy shopping support to empower them to make long-term healthy lifestyle changes. The identified members should be an Anthem Ohio Medicaid member in what we call the “contemplation” stage of readiness to change, meaning they may have regular appointments with their physicians and historically follow through with ordered labs, however, they may still have an elevated A1c and need some additional support to connect them to resources to improve their lifestyle and overall wellness. We are still working out specific details for this project, so we do have the ability to make changes based on provider input. Please reach out to [nora.trimboli@anthem.com](mailto:nora.trimboli@anthem.com) if you have any interest in collaborating.

#### *Healthy Children:*

- **Lead Screening:** We are looking to increase lead testing rates of children over the age of one, by working with practices that have the capacity do lead screening tests in office at a patients yearly well-visit. We are looking to make appointments comprehensive instead of sending patients to a lab for testing (unless additional testing is needed). If your office has the ability to do lead screenings on-site, please reach out to [Heidi.Nafziger@anthem.com](mailto:Heidi.Nafziger@anthem.com) to inquire about how we can work together to increase lead screenings in the community.
- **TytoCare Kits:** We are looking for practices to partner in distribution of Anthem purchased TytoCare kits to help identify Anthem members who qualify for an at-home kit. We are looking to work with families that have children 2 and under (specifically in rural areas) who have been to the ER 2X or more within a year for ear infections. These kits help to perform guided medical exams with a healthcare provider to service urgent, primary, preventive, and chronic care management when they are unable to get to their primary care physician.
- **Well-Visits:** Anthem is looking to increase well-visits for infants through the age of 21. Since the pandemic, well-visits are down, and children are behind on screenings and immunizations. We are looking to partner with local practices and community-based organizations to increase well-visits and access to care. If your practice is interested in collaborating on this initiative, please reach out to [Heidi.Nafziger@anthem.com](mailto:Heidi.Nafziger@anthem.com)

#### *Health Adults:*

- **Healthy Adults:** We are looking to increase access to care and annual screenings for adults over 21 years of age who are part of the Medicaid OH plan. By increasing PCP visits, we are hoping to decrease over-utilization in ED and Urgent Care visits. We are looking for opportunities to partner with providers who are looking to help increase access to care among adult population. If you are interested in collaborating on this initiative, please reach out to [Heidi.Nafziger@anthem.com](mailto:Heidi.Nafziger@anthem.com)
- **EPSDT:** Anthem BC/BS Ohio Medicaid’s process for our members under the age of 21 years old, ensures care that prevents, detects, and treats medical, social, educational, and other needs identified for our members. This care falls under our Episodic and Periodic Screening, Diagnosis and Treatment (EPSDT) coverage. This program follows State guidelines of what care is needed by age recommendations for eligible members to receive medical care, dental care, health screenings, mental screenings, and social needs assessments and interventions. The EPSDT

program is audited by internal reports that identifies eligible members that under 21 years of age. These reports identify members who are compliant with appropriate age care and those who have identified gaps in care. Anthem sends reminders to members to remind them of needed care and of services offered such as transportation to help the families and members who need connection to care. If you have any questions or concerns, please reach out to [karam.johnson@anthem.com](mailto:karam.johnson@anthem.com)

## Medicare Updates

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- Upcoming medical policy changes/policy review <https://www.anthem.com/provider/news/>
- What are the main new types of value based contracting are you engaging in – specific specialties? Multiple opportunities for Value Based Agreements
- Do you participate with the state’s HIE, Clinisync, and if so what way are you partnering with them and providers on HIE? Yes- we do receive data from providers who participate with Clinisync and the Health Collaborative.