South Carolina

Medicare Advantage

THE QUALITY CONNECTION

Medicare Advantage Provider Newsletter

Spring 2021 | Issue 3

1. Use specific language in the medical record to identify a post-hospital visit. (e.g., medication review following hospitalization) — See page 4.

2. Capture a blood pressure reading when the patient is at home using a digital device. — See page 5.

3. At no cost to you, take advantage of available clinical pharmacists to help your patients and providers with medication authorizations and increase patient adherence. — See page 11.

WHAT'S INSIDE

A MESSAGE FROM THE CMO

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Chief Medical Officer,
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I want to start by thanking every one of you and your faithful office staff for caring for patients throughout this last year. As the COVID-19 pandemic appears to be waning, I hope you are enjoying some relief from the extraordinary difficulties you have endured.

I joined BlueCross BlueShield of South Carolina as the chief medical officer for Medicare Advantage last August and have been blessed to be a part of a great team of professionals who are dedicated to making sure every member of our plan receives the right care in the right place at the right time. Along with our care management, disease management and transitions of care (TRC) teams, I am always available to work with you and your staff to make sure BlueCross BlueShield of South Carolina Medicare Advantage members are getting what they need to succeed.

This spring, we are particularly focused on encouraging our members to see their primary providers for annual wellness visits and annual physicals. Especially for members with diabetes and/or high blood pressure, we are here to work with you to help them get control of their conditions and improve their health.

Please don't hesitate to reach out to us at any time. And if there is anything I can do to assist you personally, please don't hesitate to email me at **william.logan@bcbssc.com** or call me at **864-444-8253** (cell). We want to be a part of your care team.

Sincerely,

William C. Logan Jr.,
MD, MBA, MHS

SPOTLIGHT ON HEDIS MEASURES

Transitions of Care

The National Committee for Quality Assurance has made changes over the past few years in the Healthcare Effectiveness Data and Information Set (HEDIS®) measure related to post-hospitalization care. The Transitions of Care (TRC) measure now has four submeasures:

- Notification of Inpatient Admission
- Receipt of Discharge Information
- Patient Engagement After Inpatient Discharge
- Medication Reconciliation Post-Discharge

To assist our primary care providers (PCPs) in knowing when their patients have recently been in the hospital, Medicare Advantage quality nurse navigators review inpatient authorizations and alert providers when a patient has been discharged from a hospital or post-acute setting. If you are already receiving this notification from the hospital, **please scan and store the information in the electronic medical record for that patient**.

Our care management teams offer TRC case management to all our Medicare Advantage beneficiaries. This includes communication with discharge planning teams to make sure any discharge needs are met prior to discharge. Our nurse team also follows up with the member by phone during the 30 to 60 days after discharge, depending on the needs of the member. Medication reconciliation is a standard procedure, and we will send this documentation to the member's declared PCP office for review and input into the medical record.

While we help care for your patients when they are home, it is still crucial for the member's PCP to see him or her **within 30 days** of hospital discharge to ensure medication changes, deletions or additions are consistent with the patient's plan of care. We encourage each member to follow up with his or her PCP, even if the admission was related to a surgery. We want all members to succeed after being discharged from the hospital to avoid unnecessary readmissions or severe medication errors.

Tips for HEDIS compliance for this measure:

- Always ask patients if they have been admitted to the hospital since they were last in your office.
- An RN, NP or PA in the PCP's office can complete medication reconciliation over the phone. That can count as compliance for the HEDIS measure **Transitions of Care: Medication Reconciliation Post Hospital Discharge**.
- **Be specific in documenting post-hospital follow-up appointments, such as, "Here for hospital follow-up," "recent hospitalization" or "medication review after hospitalization." Avoid generic reasons for appointment, such as, "Here for post-op," "recent surgery" or "follow-up after surgery."**
- You may request patient medical records from hospitals to review documentation. Always date and time stamp all incoming information from hospitals and save it in the patient's medical record.

- **The Current Procedural Terminology (CPT®) II Code 1111F will close the care gap for medication reconciliation, whether you completed it over the phone, via telehealth appointment or through a traditional in-office appointment. This code is eligible for a $50 incentive payment.**

SPOTLIGHT ON HEDIS MEASURES

Controlling Blood Pressure (CBP)

The HEDIS measure Controlling Blood Pressure has returned to the Star Ratings. This measure is "the percentage of members 18 – 85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled (< 140/90) during the measurement year." During medical record review, auditors consider the last BP reading of the measurement year for compliance. **To avoid medical record review, you can use CPT II codes to document the blood pressure value. A $10 per member per visit incentive is attached to these codes.**

What's new with CBP?

- Self-reported values: Members can now report their own BP readings as long as they are from a digital device.
- Revised time frame: To be eligible for this HEDIS measure, the patient must have had two outpatient visits with a hypertension diagnosis during the first six months of the measurement year and the full previous year, an 18-month review period.
- Visit types: Telephonic visits, e-visits, and virtual check-ins are now approved visit types due to expansion of telehealth visits.
- Diagnosis: This measure no longer contains the restriction that only one of two visits could be via telehealth. Now both encounters can be telehealth visits to diagnose hypertension and include the patient in the eligible population.

Provider Documentation Tips:

- If you are meeting with a member diagnosed with hypertension via a telehealth appointment, have the member take his or her BP with a home cuff and document the exact reading in the medical record.
- If a member is relaying historical BP values, an average blood pressure is allowable, but do not document a range in values.
- Never round values.
- Check blood pressure values at the beginning and end of each office visit if the first value is high.

SOCIAL DETERMINANTS OF HEALTH:

Understanding Barriers to Health Care for the Medicare Beneficiary

According to the Centers for Disease Control and Prevention (CDC), social determinants of health are non-medical conditions that influence health outcomes: where people are born, grow, live, work and age. Social determinants of health are categorized into five domains: health and health care, economic stability, education, neighborhood and built environment, and social and community context. The different domains can have a positive or negative effect on an individual's life. Health care providers play a fundamental role in assessing and ensuring all patients have their personal needs met as they relate to the different social determinants of health. This year, we want to highlight and discuss some of the social determinants of health and how our providers play a role in creating a positive patient experience.

Health Care Access and Quality

The CDC reports that 4 in 10 adults avoided medical care because of concerns related to COVID-19. Although the country saw a huge increase in telehealth opportunities and allowances from the Centers for Medicare and Medicaid Services, patients avoided telehealth appointments for care due to a lack of internet access or appropriate devices. For the Medicare beneficiary, it might have also been due to a knowledge deficit with technology or limited access to family members who could help with navigating the technology.

As the population ages, access to quality health care will be important for maintaining health and preventing or managing serious diseases. Generally, Medicare beneficiaries have more chronic health conditions and recommended preventive screenings than the younger population. Having a primary care provider to help develop a long-term health plan with patients and coordinate care across other health care providers will help improve the patients' access to health care.

SOCIAL DETERMINANTS OF HEALTH:
Understanding Barriers to Health Care for the Medicare Beneficiary

The Provider's Role

- Thorough initial and follow-up assessments of every patient's potential and known health care barriers are essential to understanding the patient perspective related to his or her health care experience. Understanding a patient's literacy levels, transportation, financial stability, living situation and more can help answer many questions related to his or her ability to understand and manage chronic conditions between office visits.
- Encourage patients to be honest and not fearful of any prejudice with the understanding that they may have access to additional services if the provider and health plan are aware of barriers they may be facing. Because these topics are still somewhat taboo in our society, some patients may not feel comfortable talking about their situations or having them documented in their medical records.
- Offer assistance where available. Refer members to our care management team for help connecting to community resources.

RISK ADJUSTMENT

Risk adjustment is more than a regulatory requirement. We believe it improves members' quality of care in several ways. One way is through accurate identification of a member's health status. This gives us the opportunity to gain a better understanding of his or her needs so we can develop new programs and appropriate interventions. By partnering with our providers and sharing data, we can better integrate clinical efforts and improve quality of care for our members.

We ask our provider partners to help us:

- Document each member disease category. In South Carolina, our more prevalent disease categories include diabetes, chronic obstructive pulmonary disease (COPD), vascular disease, heart failure and morbid obesity.
- Document all comorbidities.
- Focus on accuracy by coding diagnoses to the highest level of specificity.

To make sure our members receive the highest quality of care, we have begun a quarterly chart audit process that helps ensure accurate coding.

What is the chart audit process?

The audit process consists of a thorough review of patient encounters from various dates of service. The purpose of these audits is to encourage proper documentation, which will result in coding accuracy.

How often are these audits conducted?

We conduct our audits on a quarterly basis, and we will present the audit findings at our quality meetings. During that time, we will discuss any audit findings and give recommendations on correcting errors moving forward.

Who gets audited?

We randomly select an office or offices within your organization along with random members to begin the audit process.

What do we look for?

Initially we look for chronic conditions that are listed in our system as being unaddressed. During this audit, if we find there was enough monitoring, evaluation, assessment and treatment to code for the given condition, we will then highlight the area where we found valid documentation and list it under the audit findings. Outside of reviewing unaddressed chronic conditions, we do a thorough review to make sure you have coded all confirmed diagnoses to the highest specificity.

MEDICARE ADVANTAGE NETWORK SHARING

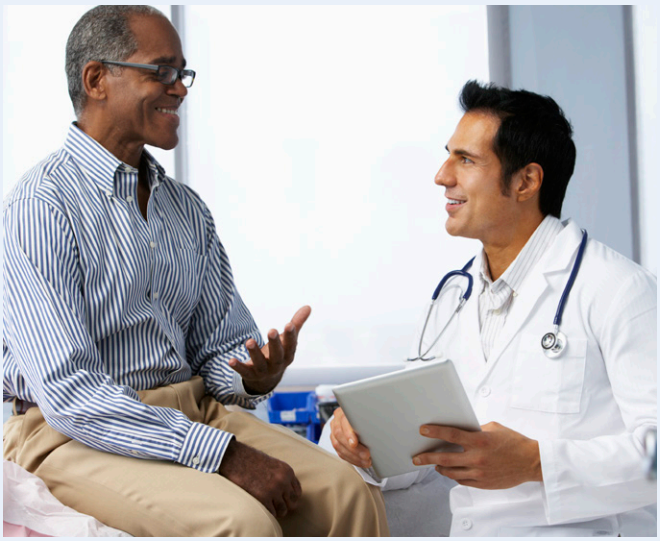
A Medicare Advantage (MA) Preferred Provider Organization (PPO) plan allows members who enroll to access providers outside of the contracted network of providers. Network sharing allows MA PPO members from other Blue® plans to get in-network benefits when traveling or living in service areas of other MA PPO plans. Medicare Advantage PPO shared networks are available in 39 states and Puerto Rico. Members from other Blue plans who qualify for the same in-network benefits when traveling here will have this symbol on their ID cards:

MA® | PPO
MEDICARE ADVANTAGE

The BlueCross Medicare Advantage Quality Improvement and STARS teams receive HEDIS quality information for some shared network Blue plans for MA PPO members who travel to or live part of the year in South Carolina. We will include this information on member care gap reports and quality reporting to our network providers when applicable.

For our providers, this means:

- You will receive member care gap reports monthly for members associated with your practice via claims data.
- These reports will include all BlueCross BlueShield of South Carolina Medicare Advantage members as well as Medicare Advantage members from other Blue plans.
- You may receive a medical record request from a Blue Cross Blue Shield plan other than South Carolina, or you may need to submit a medical record to BlueCross BlueShield of South Carolina for another Blue plan.



What Do I Need to Do as a Provider?

- Continue to verify eligibility for out-of-area MA PPO members. You can do this via the BlueCard Eligibility Line or on the web through My Insurance Manager®.
- Continue to submit claims for all Blue Cross Blue Shield members, regardless of state, to BlueCross BlueShield of South Carolina.
- Review member care gap reports frequently.
- Pay attention to open quality care gaps and patient health concerns.
- Document completed services while patients are visiting from other states.

PROVIDER RESOURCES

Provider Quality Guide

Produced in 2020, our provider quality guide is a tool for providers for quick reference on HEDIS quality measures, provider incentives, general Medicare Advantage beneficiary benefit information and more. You can find the quality guide on our Medicare Advantage provider website. It is available in print if requested. Please contact your quality nurse navigator or our program manager, Lindsey Giglio, to request additional printed copies.

Quality Nurse Navigators

Our quality nurse navigators cover the state and are available for data sharing, education on quality measures, insight to quality initiatives and any other administrative need your office may have. Our nurse team facilitates collaboration with BlueCross internal resources, including our care management teams, issues with billing or claims, and medical record collection for risk adjustment audits.

PROVIDER RESOURCES

Pharmacy Concierge

Our pharmacy teams at BlueCross Medicare Advantage are dedicated to creating a positive member and provider experience by developing a program of pharmacy concierge services. This effort is two-fold, having member- and provider-facing approaches. We designed these services to increase member satisfaction, collaboration and relationships with providers by making sure members get prescribed medications when they need them.

Member concierge services:
Daily, our pharmacy team reviews all denied and reversed pharmacy claims. Working with the member and the community pharmacy that is filling the prescription, our pharmacy team resolves the barrier to make sure the member receives the medication his or her provider has prescribed. The pharmacy team provides education on medication adherence to members and encourages the use of 90-day medication fills to decrease the members' medication costs.

Provider concierge services:
The pharmacy team works with provider offices to discuss opportunities to improve medication adherence, including offering alternative therapies based on formulary tiers. The pharmacy team is also able to work with providers to complete prior authorizations and any other administrative burden.

Our pharmacy team is ready to tailor its services to what your office needs. To discuss barriers, please contact the pharmacy team via email at **pharmacist@pharmacysyn.com**.

Medicare Advantage Webinars

Provider Services at BlueCross has scheduled provider webinars available throughout the year, which also includes a Medicare Advantage-specific program overview. In this webinar, you will receive an overview of the different Medicare Advantage plans available through BlueCross and the benefits available to members under each plan. You will also receive an overview of our quality programs along with information about prior authorizations and care management programs.

You can find more information and sign up through the **Palmetto Provider University Trainings website, Palmetto Provider University Trainings | BlueCross BlueShield of South Carolina (www.SouthCarolinaBlues.com)**.

PROVIDER RESOURCES

Other Important Contact Information

- Provider website: **www.SouthCarolinaBlues.com/web/public/brands/sc/providers/medicare-advantage**
- General provider quality and risk email: **ma.opsrequest@bcbssc.com**
- Medical record fax number: **803-870-8285**
- Names and key contacts:

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