South Carolina

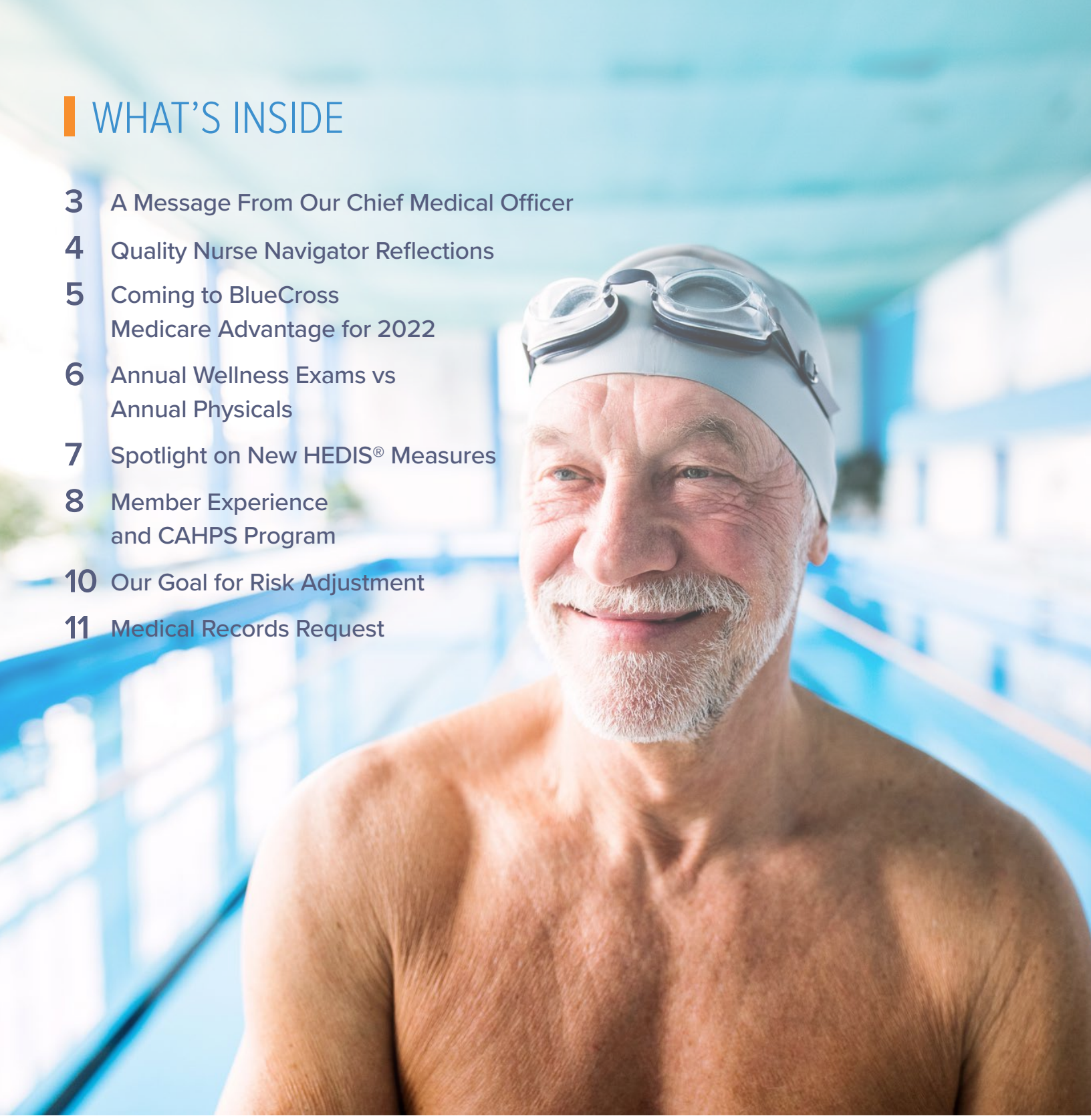
Medicare Advantage

THE QUALITY CONNECTION

Medicare Advantage Provider Newsletter

Winter 2021 | Issue 4

WHAT'S INSIDE



Be sure to visit our Provider Resource page on the Medicare Advantage website often for any changes to policies or procedures at BlueCross BlueShield of South Carolina.

Provider Resources

Medicare Advantage Provider Manual: http://SouthCarolinaBlues.com/links/maprovidermanual

Medicare Advantage Provider Website:
https://www.SouthCarolinaBlues.com/web/public/brands/sc/providers/medicare-advantage/

WE APPRECIATE YOU!

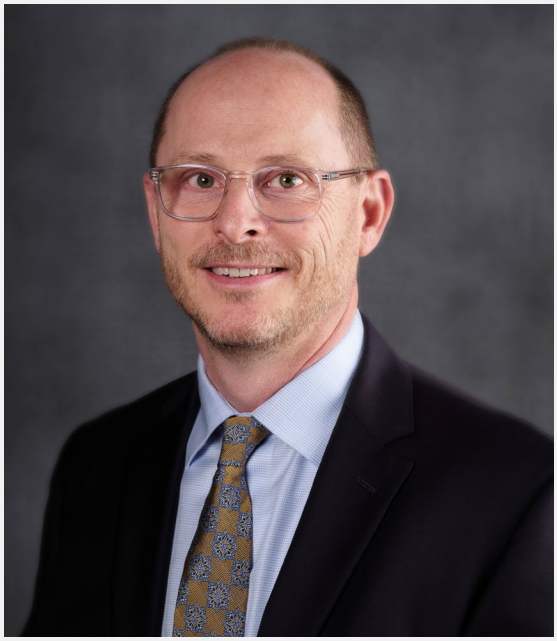
As 2021 comes to an end, we reflect on the growth of our members, provider relationships and the success of our initiatives. We realize the challenges and uncertainty due to the COVID-19 pandemic and appreciate your continued focus on providing multiple avenues of care for your patients. BlueCross continues to devote resources and attention to our most vulnerable population, and as such, our Medicare Advantage team continues to build a strong foundation for continued success with our provider network. We believe the investments in quality initiatives will be of benefit for years to come for our providers and members alike.

We are your partner in care and will strive to remain in close communication with your team as we transition into the new year.

A MESSAGE FROM OUR CHIEF MEDICAL OFFICER

Dear Providers,

We are all thankful for many things as 2021 comes to a close. We are grateful for the care you have given all of your patients during the COVID-19 pandemic, and we are especially grateful for your partnership with BlueCross and your care of our Medicare Advantage members this year. I hope you all have a great holiday season. We look forward to continuing to work with you into this new plan year.



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STAR RATINGS REMINDER

The Medicare Advantage Star Ratings program administered by the Centers for Medicare & Medicaid Services (CMS) is a quality score on a scale of 1 to 5, with five stars being the best. The goal for 2022 is to have providers reach at least the four-star rating. The BlueCross Medicare Advantage team publishes a score card for each provider office with detailed reporting of care gaps.

The Star Rating is a measure of patient outcomes (e.g., diabetes A1C, blood pressure, etc.), and high-performing providers can earn substantial financial incentives for improving patient satisfaction scores and by ensuring patients get needed services (e.g., colon cancer screening, mammogram, etc).

Do you know the Star Rating for your provider office? Contact MA.Opsrequest@bcbssc.com if you would like to discuss the details of the Star Ratings program.

QUALITY NURSE NAVIGATOR REFLECTIONS

Active engagement with our quality nurse navigator team continues to lead to improved provider scores across the state. On average, Medicare Advantage network providers who consistently work with the quality navigator team score at least half a star higher than providers who do not regularly engage with their quality navigators.

Provider Success Story for Patient Care

Danielle, one of our quality nurse navigators, reflects on a year of progress with one of her high-performing provider groups. Through active engagement via monthly scheduled quality calls, an initiative related to hypertension management was established. The goal was to educate staff members about rechecking elevated blood pressures at the end of the outpatient visit when members are less anxious and then documenting the reevaluated blood pressure. The HEDIS measure for controlling blood pressure defines a compliant blood pressure reading as 139/89 or less, and most patients at this office did not meet that definition when having their blood pressure checked only at the beginning of a visit. A second goal was to ensure all diabetic members had at least one A1C check during the year. Due to efforts of both Danielle and the provider office staff members, 100 percent of diabetic members were seen and had at least one A1C check this year. The staff was educated on the quality initiative related to blood pressure rechecks, which showed improvement in compliance in approximately 50 percent of the cases.

On an upward trend, the provider group now has an overall Star Rating of 3.696 and has a five-star rating in seven of 14 care gaps.

COMING TO BLUE CROSS MEDICARE ADVANTAGE FOR 2022

We look forward to welcoming new beneficiaries to our plans as we grow. BlueCross Medicare Advantage (MA) will now offer even more benefit plans to better suit the needs of the beneficiaries in South Carolina.

- $0-premium plans — Members will only pay their traditional Medicare Part A and Part B premiums with no additional premium paid to BlueCross BlueShield of South Carolina.

- MA-only plan — Designed for members who already have pharmacy coverage through supplemental or Veterans Affairs benefits, this plan will provide Part A, Part B and the additional Medicare Advantage perks without additional coverage for Part D drugs or restrictions to our drug formulary.

- Lower or no copays for primary care provider visits — We decreased copays across benefit plans to encourage our members to visit with primary care providers.

- Increase in annual allowance for over-the-counter benefit through Medline — Members can select packages or individual items each quarter to supplement their medical needs

- Pharmacy concierge services — Through a partnership with an independent pharmacy company, members will benefit from this concierge service that helps members with cost savings, appropriate formulary use, and prior authorization and step therapies. These pharmacy concierge services are also available to providers.

- Insulin cost savings plan — Several insulin options will now cost no more than $35 for a 30-day supply for members. This includes injectable solutions, pen injectors and cartridges from major drug manufacturers.

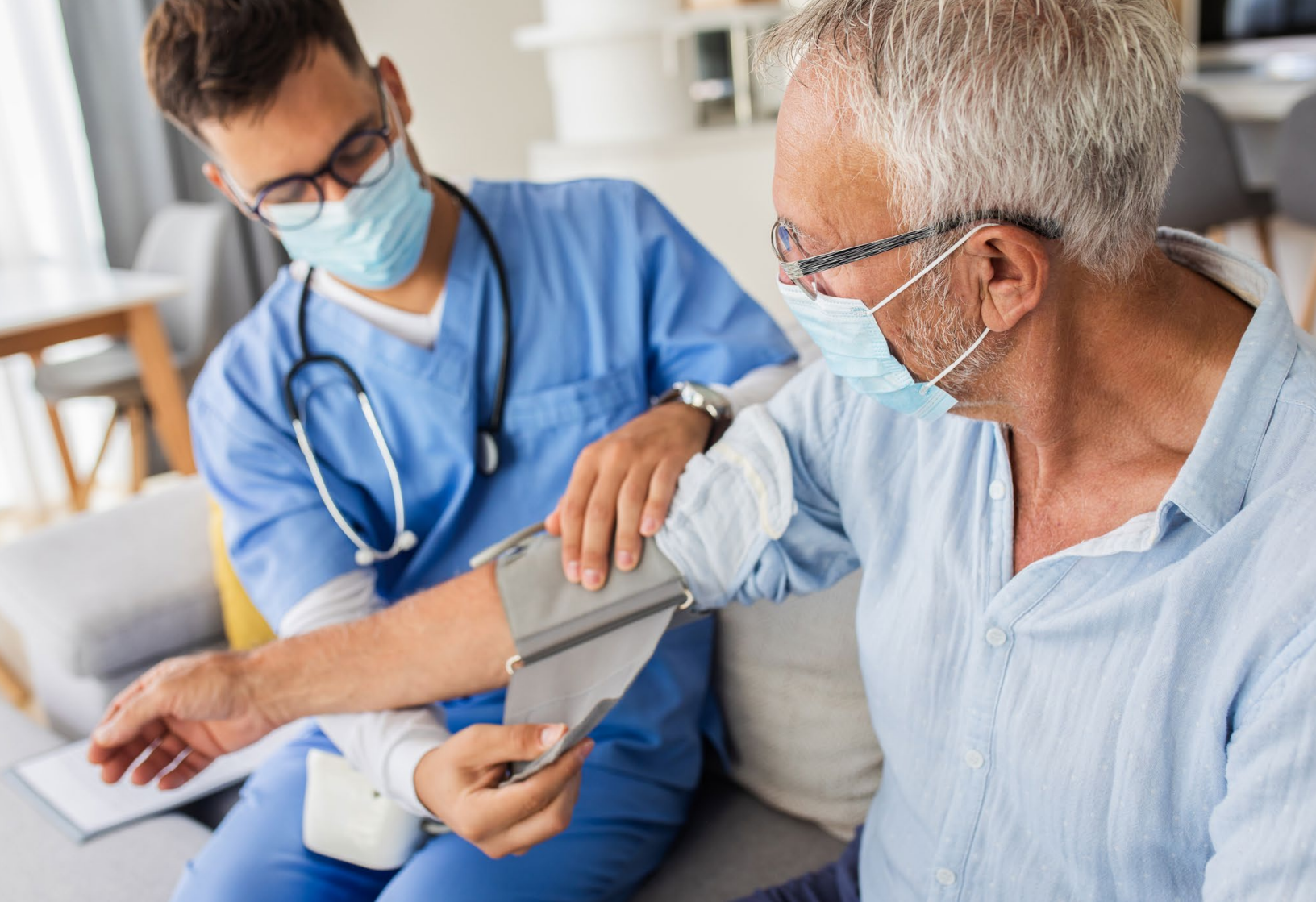
As we grow, we also continue to evaluate and change current policies and procedures. Our newly established Quality Improvement Committee, led by voices from all areas of Medicare Advantage, will begin to create policies and procedures based on CMS NCDs, LCDs, and BlueCross-established policies. As new policies are adapted to Medicare Advantage, they will be displayed for our providers on our website. They will be posted prior to going into effect so providers are able to adjust any workflows as needed.

Effective Jan. 1, 2022, there will be significant changes to our prior authorization requirements. The following now require prior authorization:

- All inpatient admissions
- Dialysis treatment initiation
- Nonemergent transportation
- Behavioral health services
- Continuous glucose monitors
- Powered mobility durable medical equipment (DME)
- Additional DME, including prosthetics, orthotics, braces and walkers
- Facility-based polysomnography
- Bariatric surgery
- LifeVest personal defibrillators

We encourage providers to review the policy page on our website or talk with your quality nurse navigator for more information.

https://www.southcarolinablues.com/web/public/brands/sc/providers/medicare-advantage/prior-authorizations-and-referrals/



ANNUAL WELLNESS VISITS VS. ANNUAL PHYSICALS

As we enter a new year, these visits will become available to members. As a provider, you should use the member's benefits to offer an annual physical to your patients, reminding them there is no cost to them. Traditional Medicare coverage only allows for one annual visit at no cost to members, which is usually used as a Medicare annual wellness exam. Our Medicare Advantage plan also offers beneficiaries a no-cost routine annual physical. We want to make sure providers can capture a comprehensive annual physical and review or document any pertinent changes to the patient's chronic conditions. This second no-cost office visit also allows our members additional time to ask questions about their condition, medications or care plan.

Both of these visit types can only be completed once in a 365-day cycle, so it is important to check each member's eligibility date for the services before rendering services.

Annual Wellness Visit	Annual Physical
G0402 (initial)	99381 – 99387
G0439 (annual)	99391 – 99397

SPOTLIGHT ON NEW HEDIS MEASURES

As the new year quickly approaches, we are preparing for two new quality measures for Medicare Advantage and the Star Ratings program. Our quality nurse navigators will be introducing these quality measures to your offices this year and working with you to plan for these new initiatives. Both measures will require a focus on data sharing between hospitals, outpatient providers and health plans across the state as part of CMS' data interoperability initiatives. For more detailed information about these new measures, please reference the BlueCross BlueShield of South Carolina Provider Quality Guide, 2022 edition.

Follow-Up After Emergency Department Visits for People With Multiple High-Risk Chronic Conditions (FMC)

In 2014, CMS found that 30.1 percent of Medicare beneficiaries had two or three chronic conditions, 20.9 percent had four or five, and 14.5 percent had six or more. Because of potential physical and functional limitations, Medicare beneficiaries are at an increased risk of adverse events following an emergency department (ED) discharge.

This HEDIS measure is designed to measure the percentage of ED visits for members ages 18 and older who have multiple high-risk chronic conditions who had a follow-up service within seven days after the ED visit. This follow-up service can take place as an outpatient visit, a telehealth visit or a telephone visit.

Transitions of Care

Medicare beneficiaries often experience longer hospital stays and inadequate understanding of diagnoses, medications and follow-up needs after an inpatient hospitalization.

Now a four-part measure, the Transitions of Care HEDIS measure will look at:

1. Notification of inpatient admission on the day of admission through 2 days after (3 total days).
2. Receipt of discharge information on the day of admission through 2 days after (3 total days).
3. Patient engagement after inpatient discharge (within 30 days of the date of discharge).
4. Medication reconciliation post discharge on the date of discharge through 30 days after (31 total days).

The provider's responsibility is to:

- Encourage all patients to notify their primary care physicians' offices if they have required an ED visit for any reason.
- Establish a work plan for patients to have contact with a nurse, case manager or practitioner in the office within seven days of all ED visits.
- Establish a workflow for documenting receipt of information from hospital systems. If faxes are received from the member's health plan, date and time-stamp the record and scan it into the electronic medical record.
- Look for information shared from the health plan related to notices of admission and discharge for your members.

MEMBER EXPERIENCE AND CAHPS PROGRAM

From providers to insurance plans, patient-centered care is emerging as a top priority for all. As the population of the country ages, a "one-size-fits-all" experience becomes less applicable. The CMS has taken a strong stance on elevating the patient experience across the health care spectrum and will be putting a larger emphasis on member experience surveys like the Consumer Assessment of Healthcare Providers and Services (CAHPS) and the Health Outcome Survey in the ratings of providers and health plans.

Ideas for Reevaluating the Patient Experience

Scheduling an appointment: Providers should view the patient experience as the moment the member schedules an appointment through any potential follow-up appointments. Automated menu options on the phone system should be clear and easy to understand and include an option to speak to a person if the patient's needs don't fit the menu options.

How easy is it for a patient to make a same-day or next-day appointment should they request one? Especially during the COVID-19 pandemic, patients may be hesitant to seek emergent care through an urgent care facility or emergency department.

Medicare beneficiaries are at a higher risk of contracting the disease and may have more health questions or concerns now than ever. Ensuring they can ask their questions or schedule an appointment can ease their concerns.

Filling out forms: Evaluate printed forms that are provided to members on arrival. When forms are copied and reused year after year, there is a potential for the print to become less legible over time. Are the forms in your office clean, legible and available in large print? Once the patient comes to the office for an appointment, how many forms is he or she required to fill out before the appointment and how frequently is he or she asked to update the forms?

Waiting times: Understanding expectations for waiting times can greatly impact the patient experience. Staff welcoming patients to the office should be honest about the time the patient will wait before being seen by a provider. Having a medical assistant complete laboratory draws, urine screenings or vital signs checks soon after the member arrives can alleviate a feeling of longer waiting times in a large waiting room. Give the patient a time frame for when the physician will see him or her.

That will help the patient have a realistic expectation for appointment wait times.

During the appointment: Make sure patients can discuss questions or concerns they have. Address things patients may not be as open to discuss, especially mental health concerns, urinary incontinence and fall prevention.

Follow-up appointment scheduling: Explain to members the length of time and reason for a follow-up appointment. ***Is the appointment for a recheck or a different reason?*** Educate the patient on how he or she should prepare for the visit, be it by fasting, expecting labs or urine samples to be drawn, etc. Have your receptionist offer reminder cards or make an appointment reminder call a few days prior to the appointment to be sure the patient is still able to keep the appointment.

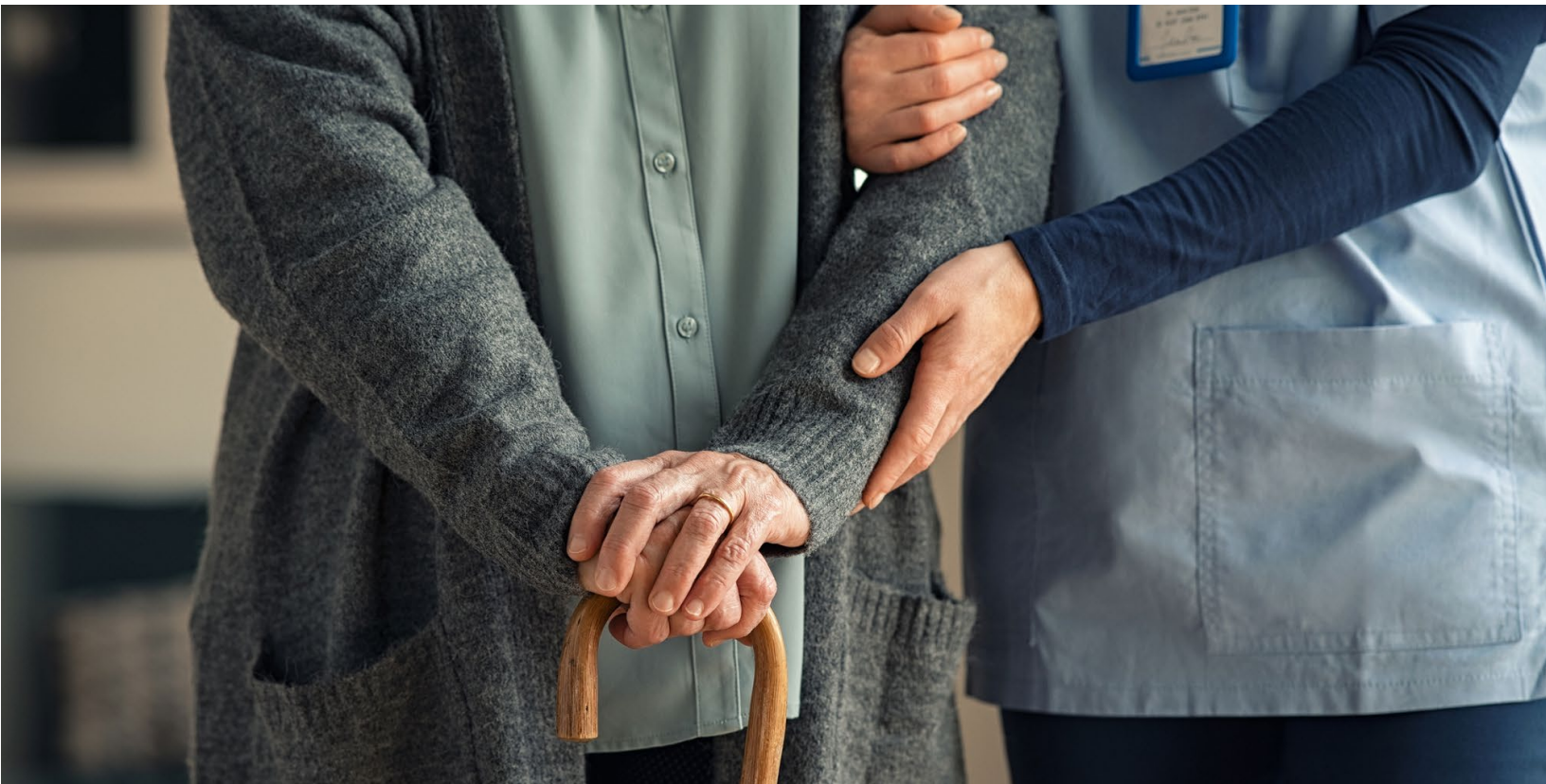
It is important for providers to begin evaluating the member experience and identifying ways to improve. Making small adjustments to processes, even just refreshing the look and feel of your office lobby, can improve the patient experience.

How BlueCross Is Working To Improve the Patient Experience

Our goal at BlueCross Medicare Advantage is to continue to provide exceptional customer service to our members. We are committed to creating a seamless approach to member care by working hand in hand with our network of providers. We are currently conducting a mock CAHPS survey to pinpoint member demographics that may need additional support or services in their areas and work with the providers in those areas to guide members to a provider who has great patient outcomes.

We have created several additional resources for our members, including quarterly newsletters with information about their benefits and seasonally appropriate topics. We host member health events to decrease social isolation and increase member engagement. These events include bingo games, healthy refreshments, and an opportunity to talk to our care management, benefit and marketing teams so members can ask questions and get answers about their benefits.

Our quality nurse navigator team is dedicated to working with our providers to make sure members are receiving the care they need between visits. Your nurse navigator is available to answer questions about our member benefits, expedite member referrals to our care management team, and guide our internal initiatives to the members who need the most support.

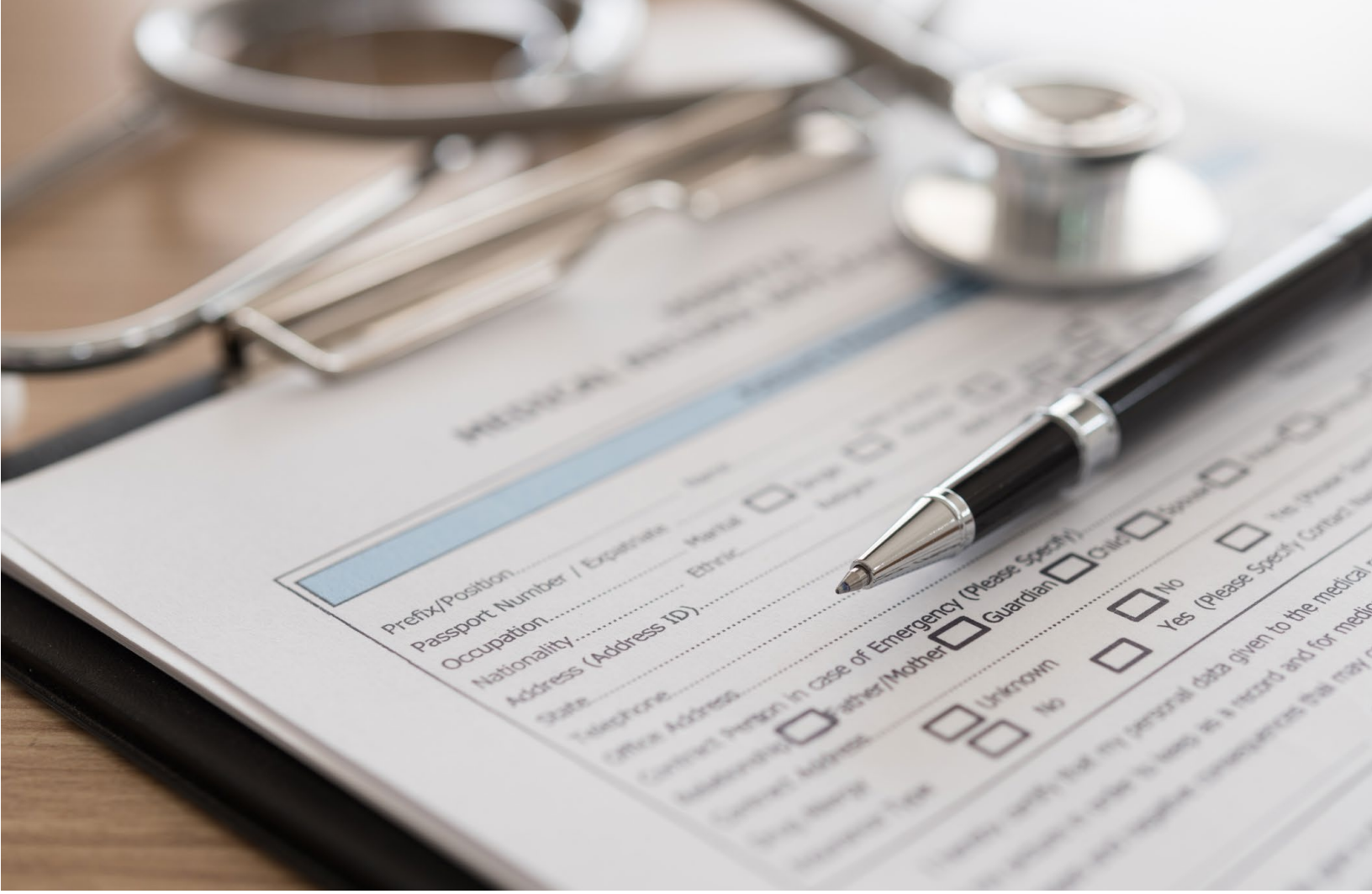


OUR GOAL FOR RISK ADJUSTMENT

As we push forward into 2022, we want our providers to continue to learn the ins and outs of risk adjustment while building a stellar relationship with their patients. With risk adjustment being an annual process, understanding the key concepts of selecting ICD-10 codes has always been our goal. This will contribute to a more accurate picture of the patient's health status. We want providers to understand that certain ICD-10 diagnosis codes map to disease groups called hierarchical condition categories (HCCs).

These conditions are then weighted with the patients demographics (age, gender, etc.) to determine a risk score. Below are some tips on how to select the most accurate diagnosis code during a patient encounter:

1. If a patient has a serious chronic condition with a manifestation or complication that has its own code, use that code instead of a specified code. ***(Example: You would code Type 2 diabetes with neuropathy instead of Type 2 diabetes unspecified.)***
2. Select not only the diagnosis codes that describe why the patient was seen but also the codes for any chronic condition that affect treatment choices. ***(Example: A patient with multiple chronic conditions is being seen for an annual well visit. The provider should review all the patient's chronic conditions being treated at that practice and by other providers.)***
3. Don't forget to report all chronic conditions annually. Risk scores reset every year, so it's important to recapture active conditions during your first patient encounter during that calendar year.



MEDICAL RECORDS REQUEST

Thank you for responding to medical record requests timely. As the year comes to an end, your office may start receiving additional medical records requests as we conduct annual audits for HEDIS and risk adjustment. As part of our commitment to quality care for our members, we review medical records so we will be better informed about our beneficiaries' health care needs and help us implement quality improvement initiatives. Your office may also receive requests for members who have BlueCross Medicare Advantage plans from other states as we participate in collaborative efforts with other Plans in the Blue® system.

To assist with the administrative burden to your staff, our quality nurse team is available to collect these medical records via on-site electronic medical records (EMR) access or remote EMR access. Currently, our quality navigator team has access to approximately 48 percent of our total members' primary care office EMR systems. Our nurses are able to quickly access records needed to close quality care gaps and review for risk adjustment purposes without burdening office staff with requests. Medical record collection is considered part of health care operations, and our team maintains compliance with HIPAA privacy rules. Please contact our team if you would allow EMR access to our nurses for the purpose of medical record collection.

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