Blue Medicare Advantage 2024 Provider Workshop

& What's new in 2025

October 2024

BlueCross BlueShield Kansas

Agenda

Section One	Introductions
Two	2025 Plan Preview
Three	Provider Policies & Procedures
Four	ASK-EDI
Five	STARS Overview – HEDIS
Six	STARS - Pharmacy Measures & Outreach Programs
Seven	STARS – Patient Experience Measures
Eight	Health Equity & SDoH
Nine	Risk adjustment
Ten	2025 CMS Updates & What's Ahead for MA
	Closing + Q&A

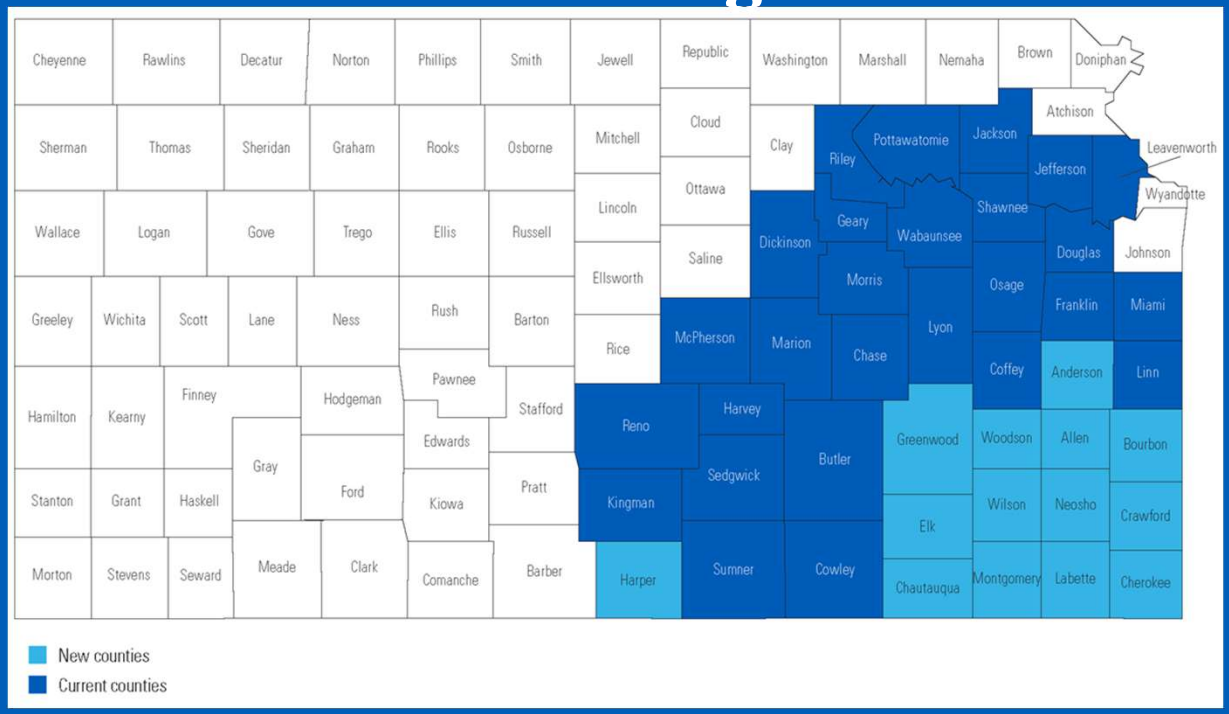
Section One

Introductions

Section Two

2025 MA Plans and Benefits Preview

Medicare Advantage Counties



Adding SEKS and South-Central Counties for 2025

Blue Medicare Advantage Plan Overview

The Power of PPO

- All plans offer both In and Out-of-Network Benefits
- Low or $0 Monthly Premium
- No Annual Deductible
- Added Benefits

ID Card & MA PPO Logo

MA | PPO
MEDICARE ADVANTAGE

2025 MA Product Offerings & Changes

Blue Medicare Advantage (PPO)

- Northeast and South Central region
- Includes Prescription, OTC, Dental, Vision, Hearing, Fitness
- Decrease INN MOOP and PCP copay

Blue Medicare Advantage Comprehensive (PPO)

- All region plan Buy-up option
- Includes Prescription, OTC, Dental, Vision, Hearing, Fitness
- Lower monthly premium and increased Dental allowance

Blue Medicare Advantage Choice (PPO)

- All region plan
- Includes Prescription, OTC, Dental, Vision, Hearing
- Increased Dental and Eyewear annual allowances for 2025

Blue Medicare Advantage Freedom (PPO)

- Medical (Part C) only plan
- Part B Premium Credit
- Includes Dental, OTC, Vision, Hearing, Fitness

Value Added Benefits

Dental
Vision
Hearing
OTC
Fitness
Meals

Dental

Embedded Preventive + Minor Comprehensive Services on all plans

Blue Medicare Advantage plans include the following embedded routine dental coverage:

- **Preventive Dental Services**
  - Routine cleanings (up to 2 every year)
  - Bitewing x-rays (up to 2 every year)
  - Oral Exams (up to 2 every year)
- **Comprehensive Dental Services**
  - Restorative
  - Endodontics
  - Periodontics
  - Extractions
  - Prosthodontics and Oral / Maxillofacial Services

	Blue Medicare Advantage (PPO) – Topeka Region	Blue Medicare Advantage (PPO) – Wichita Region	Blue Medicare Advantage Comprehensive (PPO)	Blue Medicare Advantage Choice (PPO)	Blue Medicare Advantage Freedom (PPO)
Embedded Preventive + Minor Comprehensive	$2,500 Annual Allowance	$2,500 Annual Allowance	$3,000 Annual Allowance	$2,250 Annual Allowance	$1,000 Annual Allowance
Dental Buy - up	$1,000 Annual Allowance for Minor Comprehensive Services	*Not Offered*	$1,000 Annual Allowance for Minor Comprehensive Services	*Not Offered*	*Not Offered*

Reference Evidence of Coverage, Availity, or contact customer service for additional detail on covered comprehensive services / limitations.

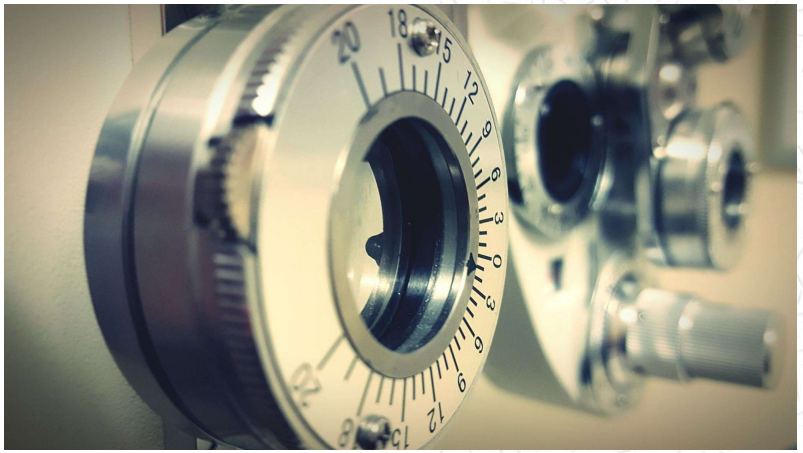
Vision

Eye Care Made Crystal Clear

- Medicare-covered diabetic eye exams and glaucoma screenings – $0 co-pay
- All other Medicare-covered eye exams & Medicare-covered eyewear– specialist co-pay
- Refractions – covered when billed with a medical exam
- Routine Eye Exam – one routine eye exam covered per year (EyeMed - $85 allowance)
- Frames, Lenses, and Contact Lenses - $150 - $300 annual eyewear allowance (EyeMed)

Claims for services covered under original Medicare should be filed to BCBSKS. Vision services (hardware) file to EyeMed.

New for 2025 – Increased eyewear allowance on Blue MA & Blue MA Choice plans



Hearing

1 Routine hearing exam + discount on hearing aids on all plans

OTC

Quarterly retail and mail-order allowance at nationwide and local drug stores, grocery stores, and retailers. Available on all plans.

Fitness

SilverSneakers Fitness Membership via Tivity Health

*Not offered on Choice plan

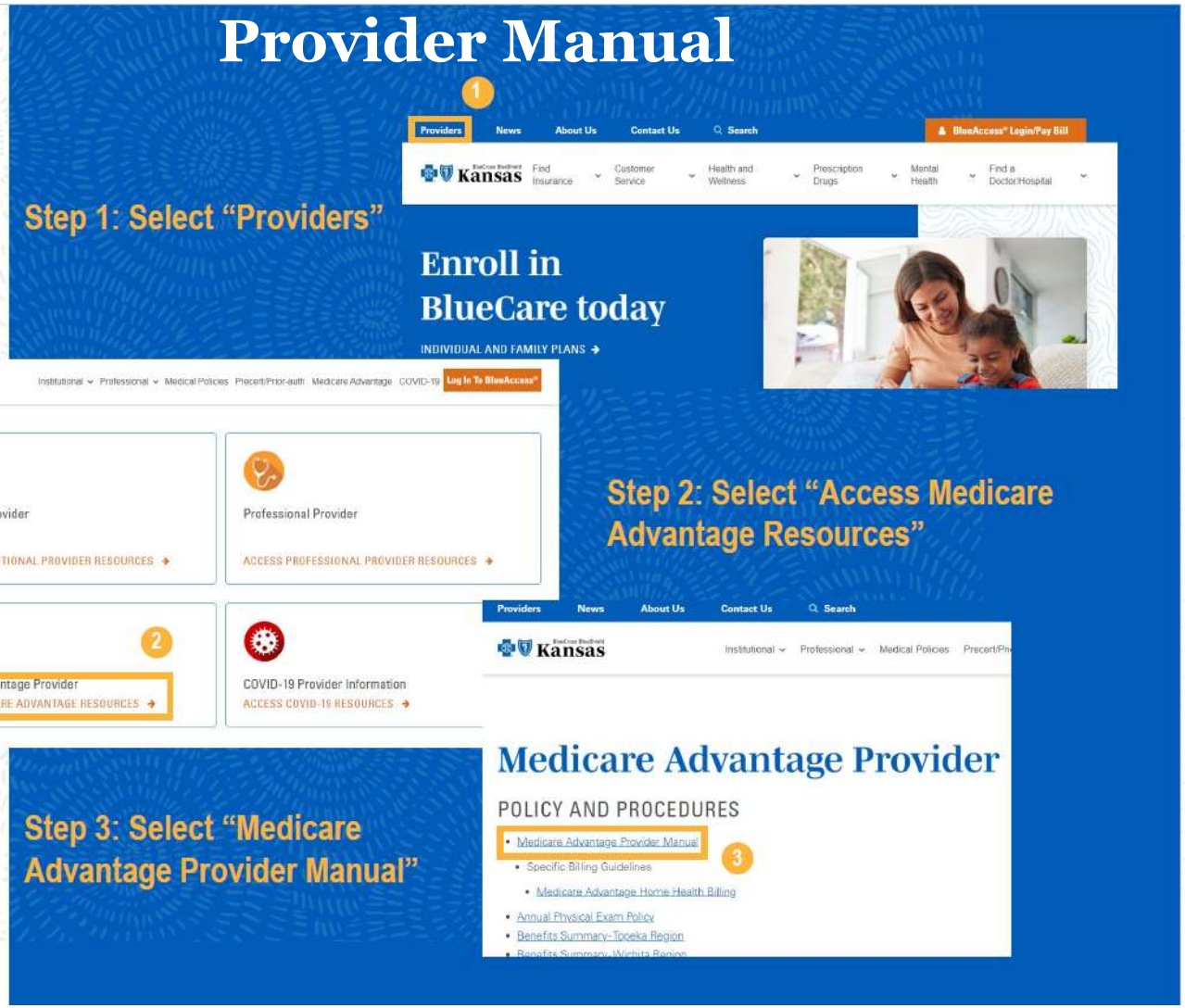
Meals

14 home delivered meals over 7-day period after hospital discharge. Available on all plans.

Section Three

Provider Policies & Procedures

Provider Manual

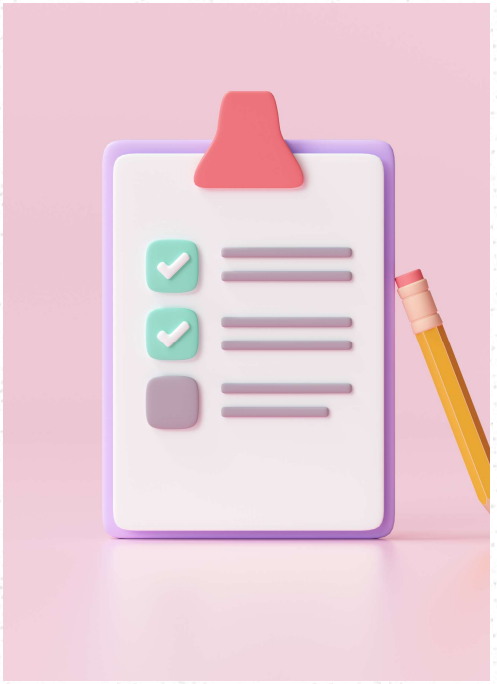


Claim Filing

- Submit electronic claims to BCBSKS, Payer ID 47163
- Submit paper claims to:

  Kansas Preferred Blue Medicare Advantage
  P.O. Box 239
  Topeka, KS 66629

- Non-Kansas providers, file with the local Blue plan
- Timely filing



Unlisted/NOC Procedure Codes

Guides for Prompt Claim Processing

Submit supporting documentation, records, reports for medical and surgical procedures.

- Include narrative/description on claim form where appropriate
- For unlisted DMEPOS items, include UPN in box 19, and manufacturer's invoice

Unclassified/Unlisted Drug Codes

- NDC Qualifier (N4)
- NDC Billing Number (11 digits, no spaces or characters)
- Product package size unit of measure
- NDC Units
- One unit of service (Box 24G / Field 46)

DME Provider Records

Ensure you're ready to bill DME HCPCS Codes

If it's billed to the DMERC, Complete DME Credentialing

- DME Supplier record is needed for HCPCS codes that are normally filed to the DME Medicare Contractor (Noridian)
- If you have a separate DME NPI, utilize for Blue MA
- Differs form commercial business
- Special Instructions for claims filing

Chiropractic Billing

Coding & Coverage

Blue MA follows Medicare/Part B coverage and billing guidelines

- Spinal Chiropractic Manipulative Treatment (CMT) only (CPT Codes 98940-98942)
- Active Treatment / AT Modifier
- Segmental and somatic diagnosis (precise level of subluxation) primary, symptom/condition codes secondary (neuromusculoskeletal condition necessitating treatment)
- Date of initiation of treatment course
- Documentation requirements

Additional Information & Resources:

WPS GHA Local Coverage Article A56273 “Billing and Coding: Chiropractic Services)

Publication 100-02 Medicare Benefit Policy Manual Chapter 15 Covered Medical and Other Health Services: §30.5, 40.4, 220, 240

Publication 100-04 Medicare Claims Processing Manual, Chapter 12 Physicians/Nonphysician Practitioners, §220

Kansas Preferred Blue Medicare Advantage Provider Manual

Member Evidence of Coverage

Medical Policy & Reimbursement

CMS Resources

Claims are processed in accordance with Original Medicare:

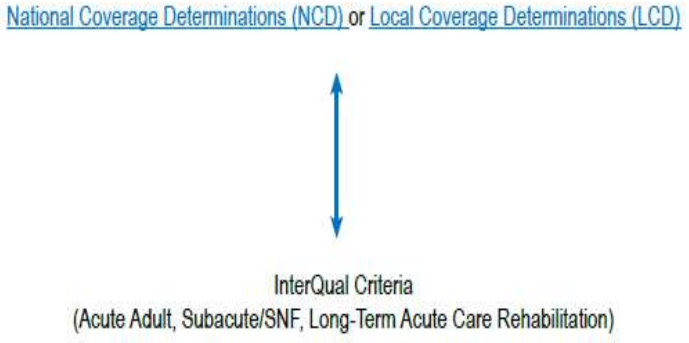
- National Coverage Determinations
- Local Coverage Determinations
  - WPS GHA (J5 MAC Part B) or Noridian (JD DEMRC)
- Billing Articles

Providers should follow all applicable Original Medicare guidelines, including:

- Diagnosis code to the highest level of specificity. When a fourth or fifth digit exists for a code, you must supply all applicable digits.
- Follow National coding guidelines (NCCI).
- Medicare Part B supplier number, national provider identifier and federal tax identification number.

Medical Policy Hierarchy

In terms of the sequence of prior authorization review, BCBSKS will first reference existing National Coverage Determinations (NCD) or Local Coverage Determinations (LCD). If neither of these exist, BCBSKS will reference InterQual criteria (Acute Adult, Subacute/SNF, Long-Term Acute Care Rehabilitation).



RHC & FQHC Billing

Providers must bill Blue MA in the same manner they bill Original Medicare.

Services performed at an RHC payable as a RHC, or performed at an FQHC payable as an FQHC, are billed to Blue MA on a UB-04 claim form.

- RHC & FQHC services outside of the CMS all inclusive rate should be billed on a CMS 1500 claim form.
- Reimbursement will be the same as original Medicare.
- A copy of the current rate letter is necessary to be provided at initial contracting and each following year when CMS provides updated interim rate letters for RHC and CAH.
- Reference Medicare Claims Processing Manual, Chapter 9, and Pub. 100-02, Medicare Benefit Policy Manual, Chapter 13.

Prior Authorization

For medical, only required for the following inpatient services:

- Acute Inpatient Hospital Admissions
- 14 Day Bundling for Readmissions
- Long Term Acute Care Hospital Admission
- Skilled Nursing Facility Admissions
- Inpatient Rehabilitation Admissions
- Mental Health and SUD Inpatient Admissions

Inpatient Prior Authorization Submission

Phone:

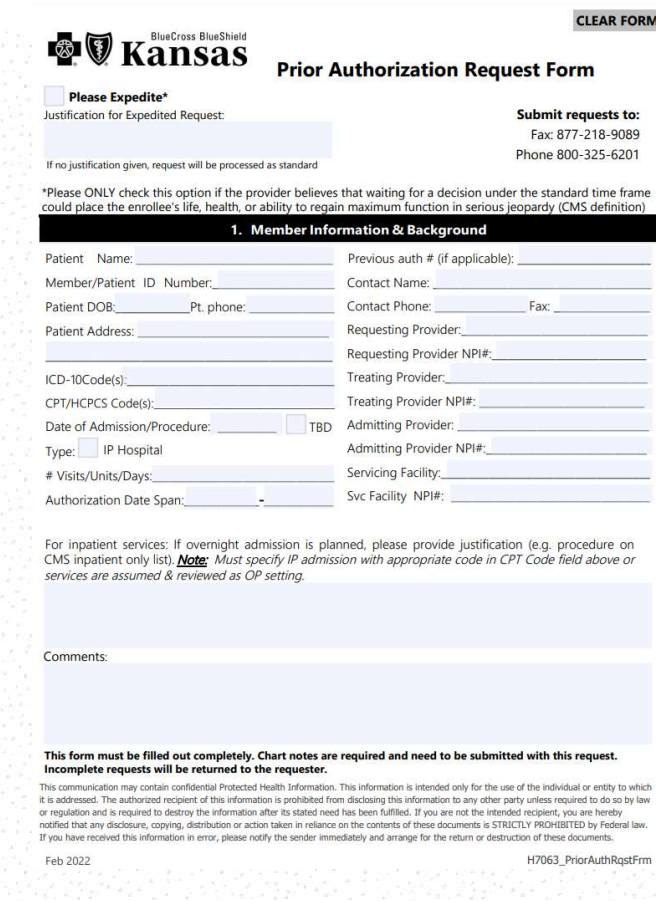
- Prior Auth/Utilization Management team – 800-325-6201
- MA Provider Services (eligibility/benefits) – 800-240-0577

Online:

- Symphony
  - Login and resources through the BlueMA Medical Provider Portal
  - Availity > Payer Spaces > BCBSKS > Blue MA Medical > Authorizations

Fax:

- 877-218-9089



CLEAR FORM

BlueCross BlueShield Kansas

Prior Authorization Request Form

☐ **Please Expedite***

Justification for Expedited Request:

If no justification given, request will be processed as standard

Submit requests to:
Fax: 877-218-9089
Phone 800-325-6201

*Please ONLY check this option if the provider believes that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy (CMS definition)

1. Member Information & Background

Patient Name: _____
Member/Patient ID Number: _____
Patient DOB: _____ Pt. phone: _____
Patient Address: _____
_____
ICD-10Code(s): _____
CPT/HCPCS Code(s): _____
Date of Admission/Procedure: _____ ☐ TBD
Type: ☐ IP Hospital
Visits/Units/Days: _____
Authorization Date Span: _____ - _____

Previous auth # (if applicable): _____
Contact Name: _____
Contact Phone: _____ Fax: _____
Requesting Provider: _____
Requesting Provider NPI#: _____
Treating Provider: _____
Treating Provider NPI#: _____
Admitting Provider: _____
Admitting Provider NPI#: _____
Servicing Facility: _____
Svc Facility NPI#: _____

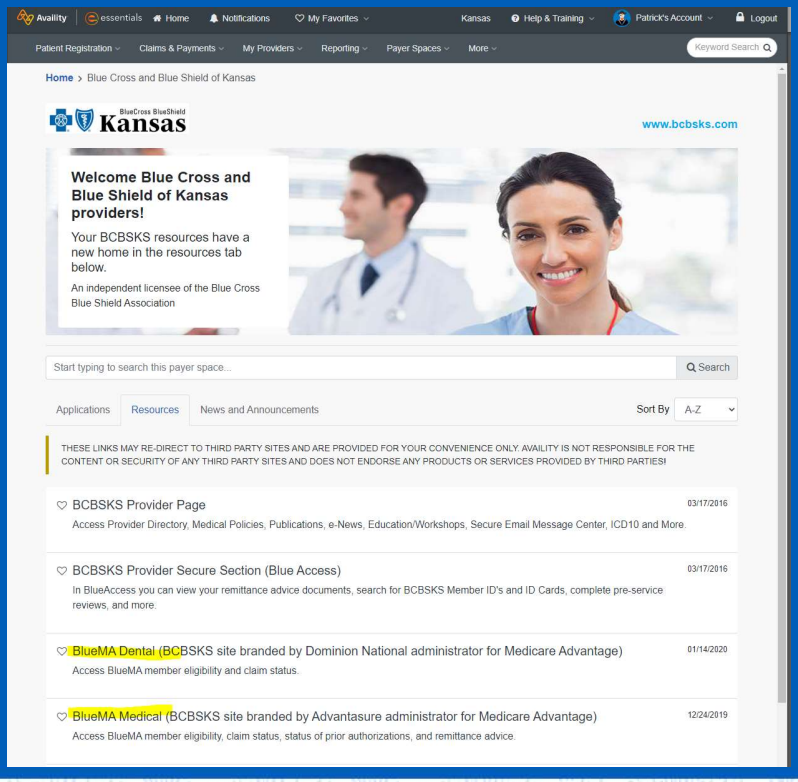
For inpatient services: If overnight admission is planned, please provide justification (e.g. procedure on CMS inpatient only list). ***Note:*** *Must specify IP admission with appropriate code in CPT Code field above or services are assumed & reviewed as OP setting.*

Comments:

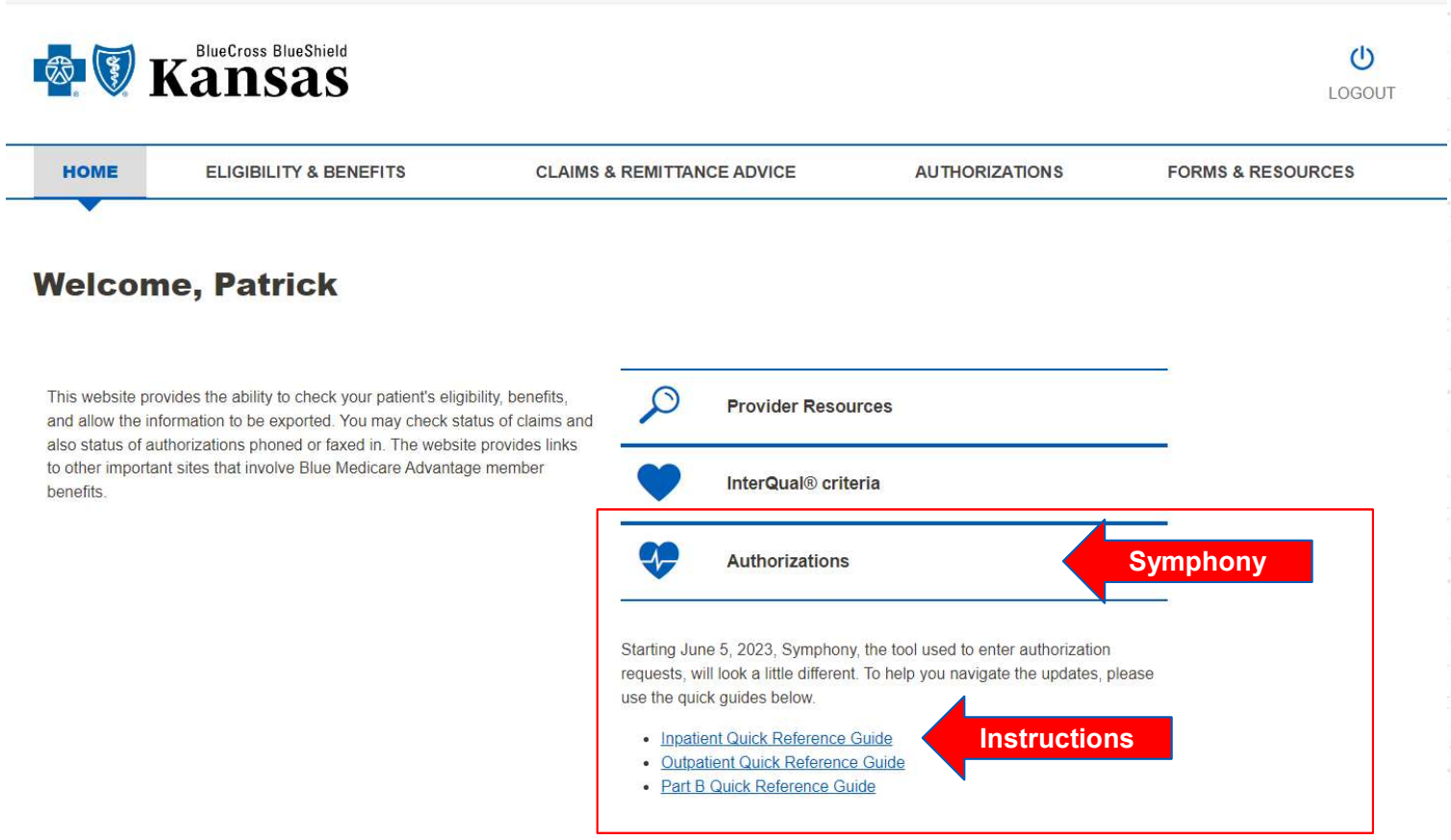
This form must be filled out completely. Chart notes are required and need to be submitted with this request. Incomplete requests will be returned to the requester.

Feb 2022 H7063_PriorAuthRqstFrm

Provider Self Service



Online Inpatient Prior Authorization



Post-Service Appeals & Payment Disputes

Payment Disputes for Kansas Blue MA

- Call Provider Inquiry Services
- Submit written First-Level Appeal within 60 days of the initial determination
- Will be reviewed and responded to within 60 days of receipt

Appeal/Dispute Phone	Appeal/Dispute Fax	Mail Effective 1/1/2024
800-240-0577	800-976-2794	BCBSKS PO Box 211421 Eagan MN 55121

Post-Service Appeals & Payment Disputes

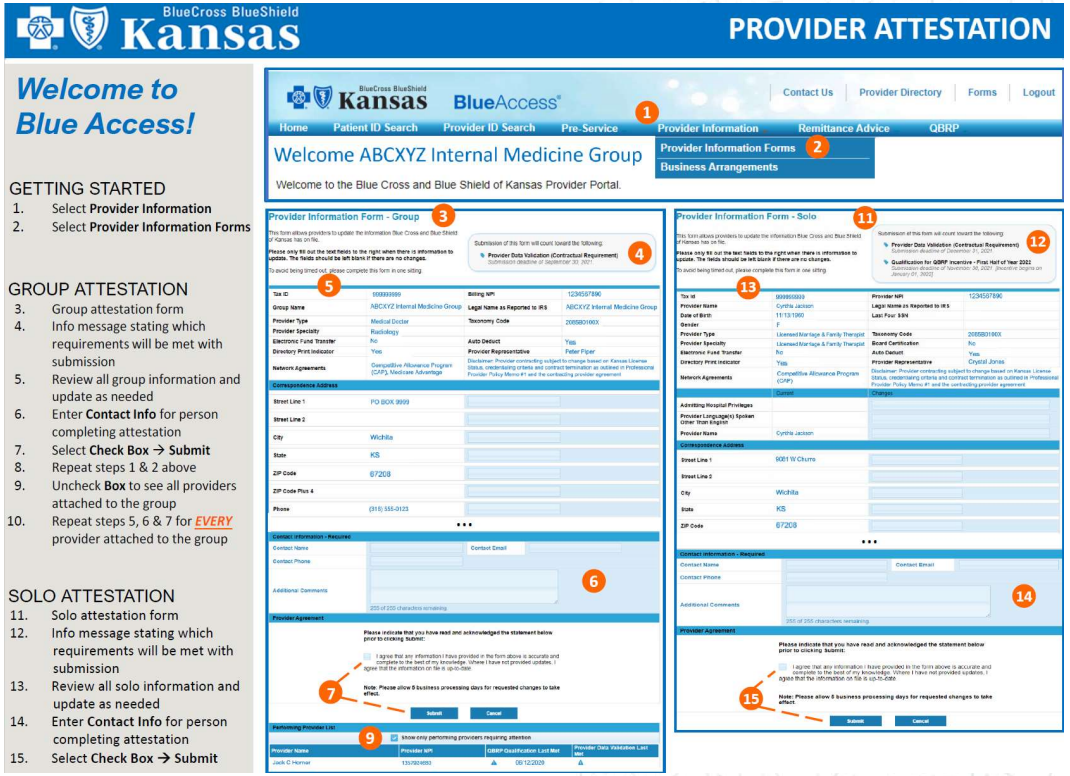
Second-Level

- Must be submitted within 60 days of the initial determination
- Submitted by fax or mail
- The decision rom the Second-Level Appeal will be final and binding.

Appeal/Dispute Phone	Appeal/Dispute Fax	Mail Effective 1/1/2024
800-240-0577	800-976-2794	BCBSKS PO Box 211421 Eagan MN 55121

BCBSKS Provider Portal Attestation

- Consolidated Appropriations Act (CAA)
- 90-day attestation requirement
- Separate from Availity portal
- Group and Individual provider attestation



CMS Demographics Attestation

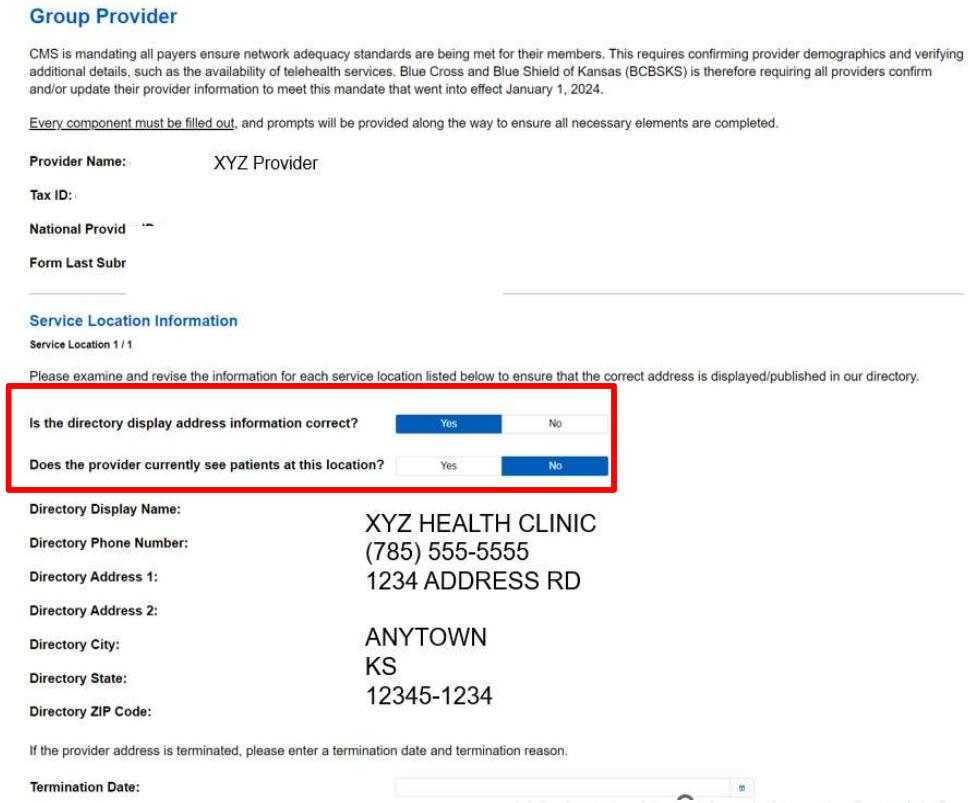
MA Providers Must Complete Annually

- Separate from CAA Attestation completed every 90 days (“Provider Information > Forms”)
- Ensures accuracy of directory data across all BCBSKS systems
- Located in BlueAccess® BCBSKS Provider Secure portal through your Availity Essentials Single Sign-On

CMS Demographics Attestation - Group Steps

Step 1 – Confirm Service Locations

- "Is the directory display address information correct?"
  - ✓ Click "YES" to confirm
  - ✓ Click "NO" if update needed
    - "Does the provider currently see patients at this location?"
      - "YES" to update address (e.g. phone number or address line.)
      - "NO" to terminate address (prompted for term date and reason)



Group Provider

CMS is mandating all payers ensure network adequacy standards are being met for their members. This requires confirming provider demographics and verifying additional details, such as the availability of telehealth services. Blue Cross and Blue Shield of Kansas (BCBSKS) is therefore requiring all providers confirm and/or update their provider information to meet this mandate that went into effect January 1, 2024.

Every component must be filled out, and prompts will be provided along the way to ensure all necessary elements are completed.

Provider Name: XYZ Provider

Tax ID:

National Provid

Form Last Subr

Service Location Information

Service Location 1 / 1

Please examine and revise the information for each service location listed below to ensure that the correct address is displayed/published in our directory.

Is the directory display address information correct? Yes | No

Does the provider currently see patients at this location? Yes | No

Directory Display Name: XYZ HEALTH CLINIC

Directory Phone Number: (785) 555-5555

Directory Address 1: 1234 ADDRESS RD

Directory Address 2:

Directory City: ANYTOWN

Directory State: KS

Directory ZIP Code: 12345-1234

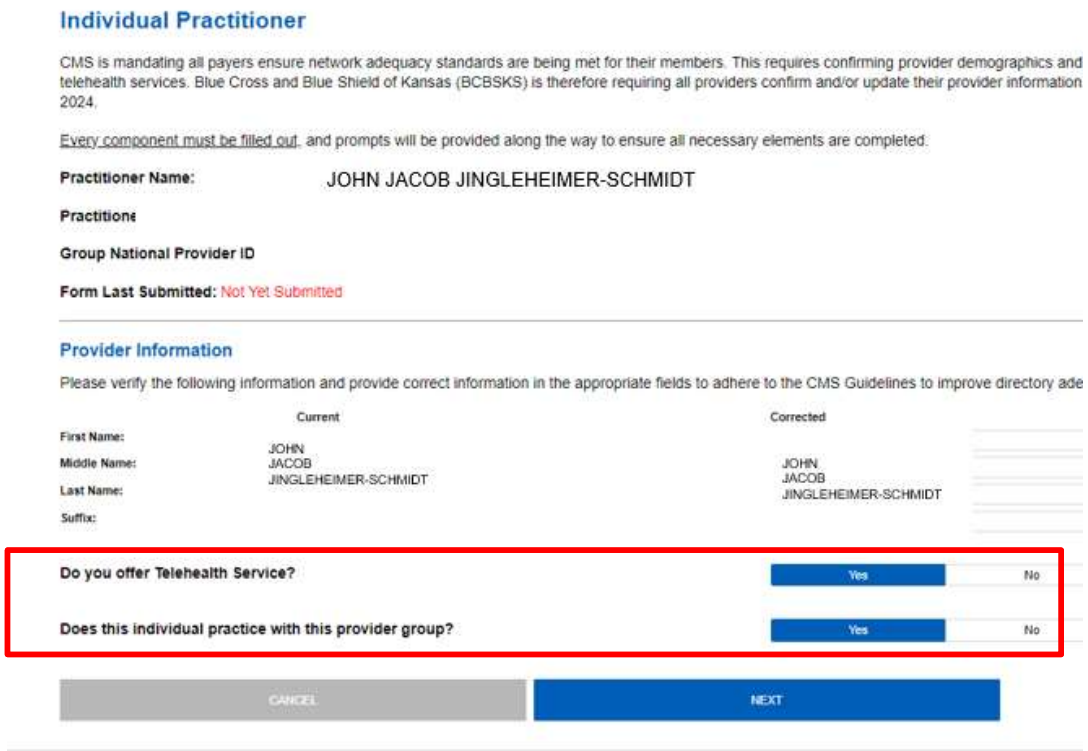
If the provider address is terminated, please enter a termination date and termination reason.

Termination Date:

CMS Demographics Attestation - Practitioner Steps

Step 2 – Confirm Individual Practitioner(s) – Professional Billing Groups Only

- "Do You offer Telehealth Service?"
  - ✓ "YES" or
  - ✓ "NO"
- "Does this individual practice with this provider group?"
  - "YES" to confirm
  - "NO" to terminate practitioner linked to this group
  - If NO – prompts termination date and reason



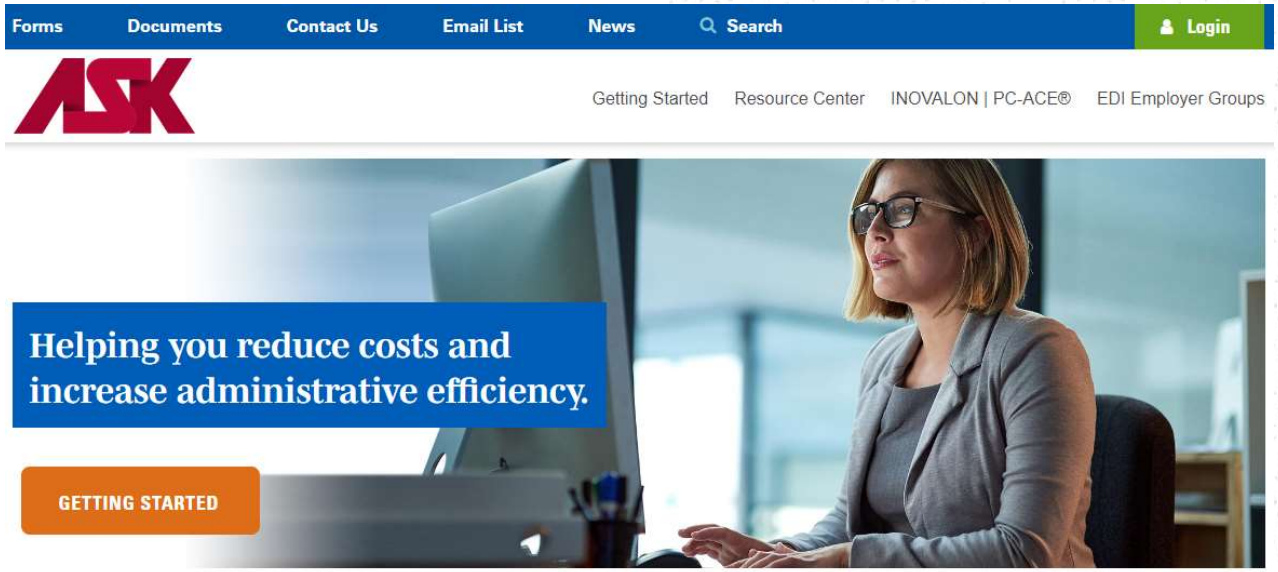
Section Four

Electronic Data Interchange

ADMINISTRATIVE SERVICES OF KANSAS

www.ask-edi.com

- Forms
- Documents
- Contact Us
- Email List
- News
- Resource Center



Forms

- Sign up for electronic remittance advice (835s) and Medicare Crossover remittance advice
- Enroll as a new trading partner for claim transactions
- Update trading partner contact information

Documents

- Companion Guides
- Acknowledgments Manual
- Some ICD-10 specific edit information
- Other Manuals

Contact Us

- Secure online form for submitting questions
- Information needed when calling
- Phone menu options
- ASK mailing address
- Scheduled downtime

Email List/News

- Sign up for one or more of our email lists such as:
  - Latest News
  - Companion Documents
  - Electronic Remits
- Ask publishes news posts for updates or planned maintenance outside our standard maintenance window
- News posts are followed by an email sent to anyone subscribing to the applicable mailing list

Electronic Remittance Advice (ERA)

- ✓ Health Care Claim Payment Advice – 835
- ✓ Once a claim has been processed a remittance advice is created
- ✓ If you have signed up for electronic remittance advice these are sent to EDI for delivery

Medicare Advantage 835s

- Signing up for BCBSKS 835s also includes enrollment in Medicare Advantage 835s
- Medicare Advantage 835s are not applicable for dental providers
- Delivered to EDI Wednesday morning and we deliver these to you and/or your clearinghouse
- Not available in BlueAccess
- Identified by filenames starting with AD835*.*

Why EDI?

Filing MA Claims Electronically

- File claims just like BCBSKS claims
  - Payer ID 47163
  - Include the ID prefix – this is used to determine if the claim should be sent through as MA

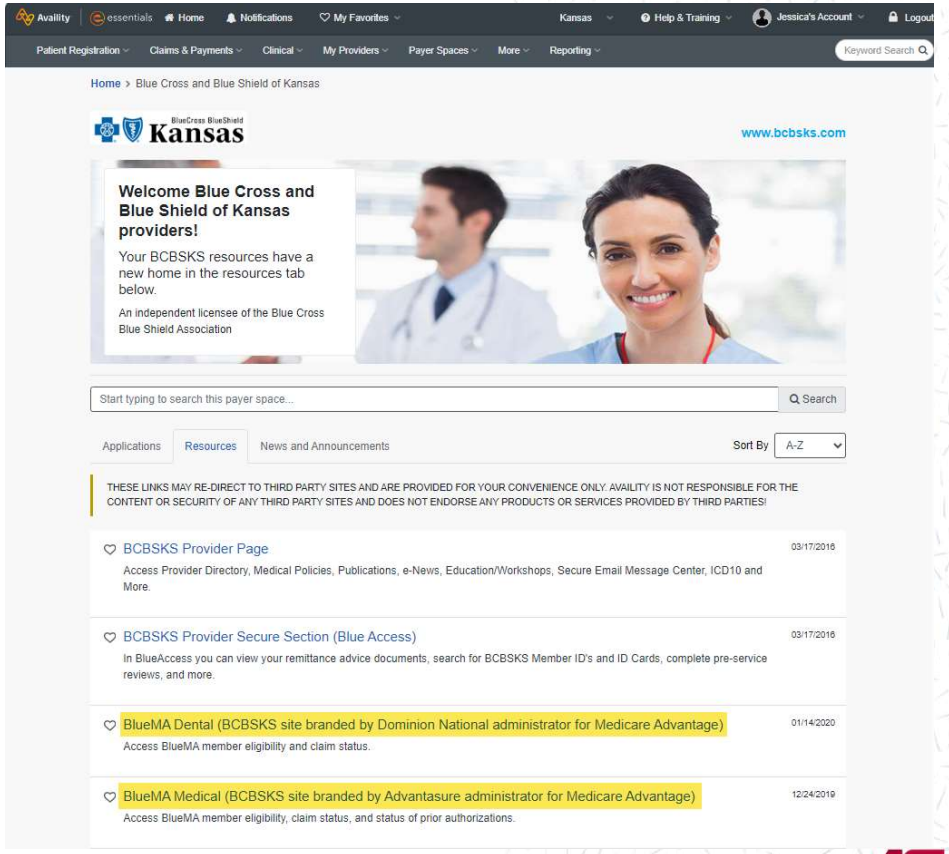
Other electronic transactions available

- Eligibility and Benefit Inquiries
- Claim Status inquiries
- Electronic Remittance Advice

Payer Spaces for Medicare Advantage

Payer Spaces in Availity includes resources for MA providers

- BlueMA Dental
  - Member Eligibility
  - Claim Status
- BlueMA Medical
  - Member Eligibility
  - Claim Status
  - Prior Authorization Status

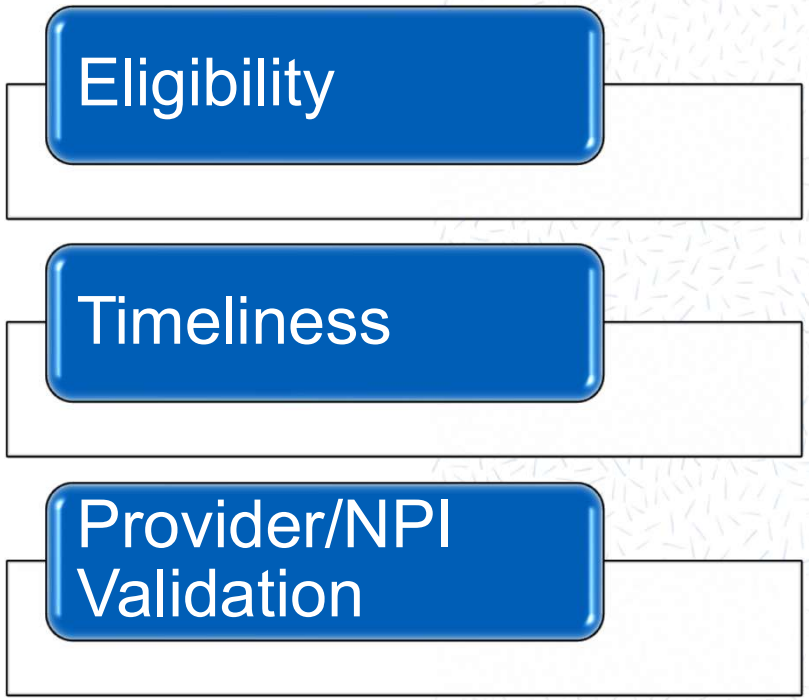


Electronic Claims

EDI applies edits to all claims received

- If a claim is rejected in EDI it is not sent to the payer for processing
  - Detailed information is available per billing NPI upon request
- Assistance in understanding a specific EDI claim rejections is available by contacting the EDI help desk
- Results of claim editing are provided via acknowledgment transactions
  - 999 Implementation Acknowledgment
  - 277CA Claim Acknowledgment

Examples of rejections:



EDI Help Desk

Available 7:00 a.m. – 4:30 p.m. Monday through Friday

1-800-472-6481 option 1

Email: askedi@ask-edi.com

Website: www.ask-edi.com

Please have the following information available when calling

Billing NPI

Seven-digit trading partner number (if available)

- Claim inquiries
  - Member ID, claim amount, date of service, account number
- Remittance advice inquiries
  - Check date, amount and number

Resources

www.ask-edi.com

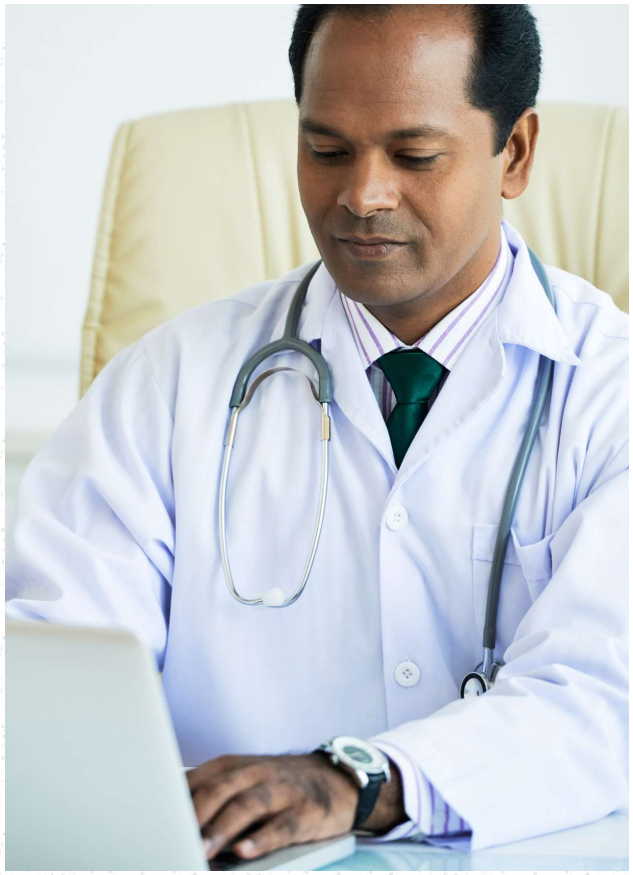
INOVALON | PC-ACE

- Free billing software

X12 standardized HIPAA code sets

https://x12.org/codes

- Health care code lists
  - Claim status category codes
  - Claim status codes



Section Five

STARS Overview

What is the Medicare star ratings program?

The Centers for Medicare & Medicaid Services (CMS) developed the Medicare star ratings program to help consumers compare Medicare Advantage (MA) health plans based on quality and performance

Ratings are determined using different data sets including, but not limited to:

- HEDIS® Data
- Prescription Drug Event
- CAHPS Survey
- HOS
- Operations Data

By providing high-quality care to patients in a timely manner, providers play a critical role in the star ratings program.

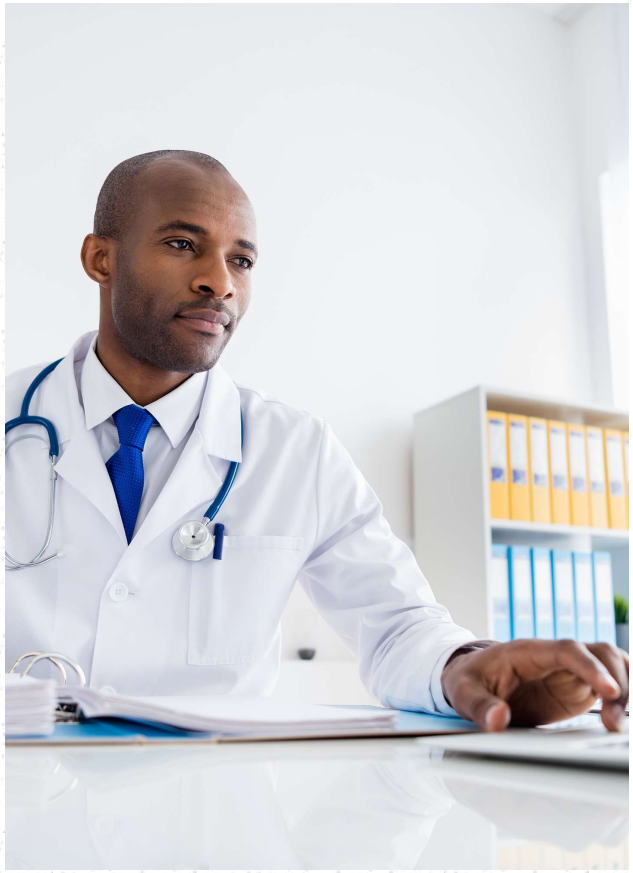
2024MY HEDIS® Measures

Addressing Gaps in Care

HEDIS® measures performance in health care where improvements can make a meaningful difference in people's lives.

Measures collected for 2024CY:

- Breast Cancer Screening (BCS)
- Colorectal Cancer Screening (COL)
- Controlling Blood Pressure (CBP)
- Eye Exam for Patients with Diabetes (EED)
- Glycemic Status Assessment for Patients Health Evaluation (GSD)
- Kidney Health Evaluation for Patients with Diabetes (KED)
- Osteoporosis Management in Women with a Fracture (OMW)
- Statin Therapy for Patients with Cardiovascular Disease (SPC)
- Statin Use in Persons with Diabetes (SUPD)
- Transitions of Care (TRC)
  - Notification of Admission
  - Receipt of Discharge Information
  - Medication Reconciliation
  - Patient Engagement
- Follow Up after ED Visit with Multiple Chronic Conditions (FMC)
- Plan All Cause Readmissions (PCR)
- Medication Adherence – Cholesterol, Diabetes, Hypertension

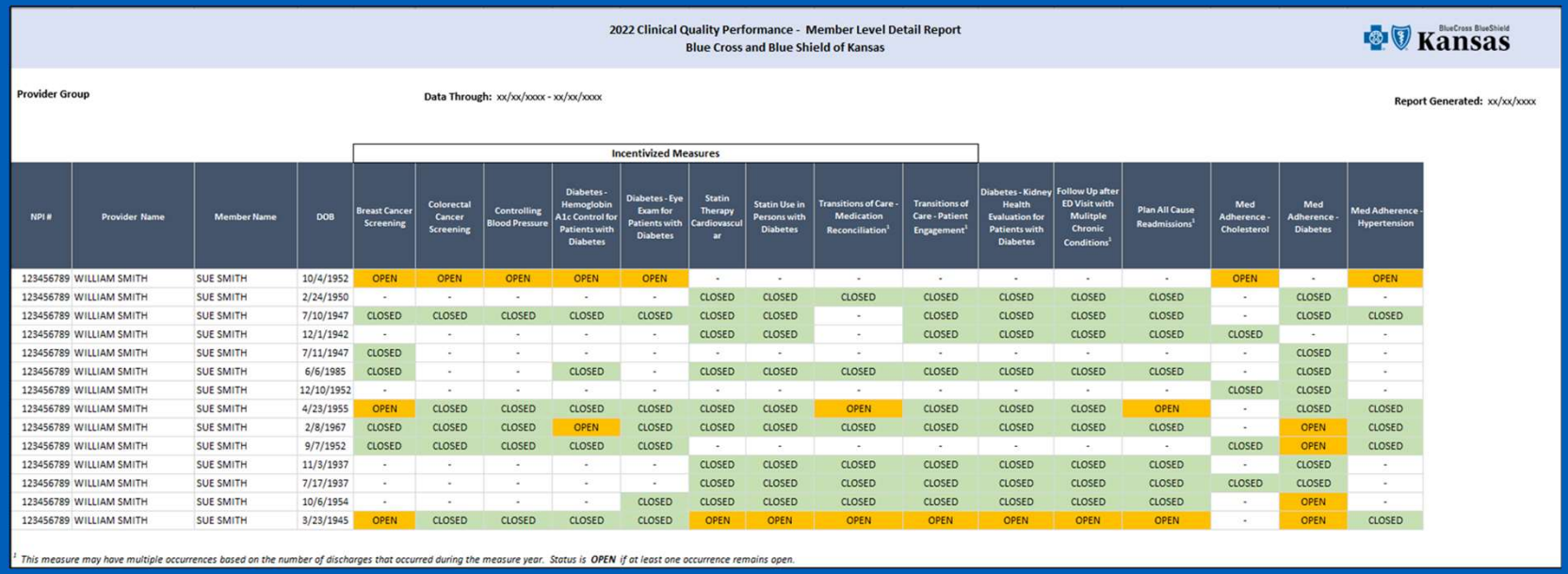


2024 MA Provider Incentives

Incentive Payout	Measure(s)
Quality Performance Measures	
$50	Uncontrolled Blood Pressure
$300	Annual Wellness Visit
Effectiveness of Care HEDIS Measures	
$50	Medication Adherence – Cholesterol*, Medication Adherence – Diabetes*, Medication Adherence – Hypertension*
$100	Breast Cancer Screening, Colorectal Cancer Screening, Eye Exam for Patients with Diabetes, Glycemic Status Assesment for Patients with Diabetes, Statin Therapy for patients with Cardiovascular Disease, Statin Use in Persons with Diabetes, Transitions of Care – Medication Reconciliation, Transitions of Care – Patient Engagement
$200	Controlling Blood Pressure

*Previously reported measures, newly incentivized for 2023
Incentive is a fixed dollar amount per star gap closed for the attributed members by the end of the measurement year

HEDIS® & Incentive Support



2022 Clinical Quality Performance - Member Level Detail Report
Blue Cross and Blue Shield of Kansas

BlueCross BlueShield Kansas

Provider Group

Data Through: xx/xx/xxxx - xx/xx/xxxx

Report Generated: xx/xx/xxxx

				Incentivized Measures															
NPI #	Provider Name	Member Name	DOB	Breast Cancer Screening	Colorectal Cancer Screening	Controlling Blood Pressure	Diabetes - Hemoglobin A1c Control for Patients with Diabetes	Diabetes - Eye Exam for Patients with Diabetes	Statin Therapy Cardiovascular	Statin Use in Persons with Diabetes	Transitions of Care - Medication Reconciliation[1]	Transitions of Care - Patient Engagement[1]	Diabetes - Kidney Health Evaluation for Patients with Diabetes	Follow Up after ED Visit with Mulitple Chronic Conditions[1]	Plan All Cause Readmissions[1]	Med Adherence - Cholesterol	Med Adherence - Diabetes	Med Adherence - Hypertension
123456789	WILLIAM SMITH	SUE SMITH	10/4/1952	OPEN	OPEN	OPEN	OPEN	OPEN	-	-	-	-	-	-	-	OPEN	-	OPEN
123456789	WILLIAM SMITH	SUE SMITH	2/24/1950	-	-	-	-	-	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	-	CLOSED	-
123456789	WILLIAM SMITH	SUE SMITH	7/10/1947	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	-	CLOSED	CLOSED	CLOSED	CLOSED	-	CLOSED	CLOSED
123456789	WILLIAM SMITH	SUE SMITH	12/1/1942	-	-	-	-	-	CLOSED	CLOSED	-	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	-	-
123456789	WILLIAM SMITH	SUE SMITH	7/11/1947	CLOSED	-	-	-	-	-	-	-	-	-	-	-	-	CLOSED	-
123456789	WILLIAM SMITH	SUE SMITH	6/6/1985	CLOSED	-	-	CLOSED	-	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	-	CLOSED	-
123456789	WILLIAM SMITH	SUE SMITH	12/10/1952	-	-	-	-	-	-	-	-	-	-	-	-	CLOSED	CLOSED	-
123456789	WILLIAM SMITH	SUE SMITH	4/23/1955	OPEN	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	OPEN	CLOSED	CLOSED	CLOSED	OPEN	-	CLOSED	CLOSED
123456789	WILLIAM SMITH	SUE SMITH	2/8/1967	CLOSED	CLOSED	CLOSED	OPEN	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	-	OPEN	CLOSED
123456789	WILLIAM SMITH	SUE SMITH	9/7/1952	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	-	-	-	-	-	-	-	CLOSED	OPEN	CLOSED
123456789	WILLIAM SMITH	SUE SMITH	11/3/1937	-	-	-	-	-	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	-	CLOSED	-
123456789	WILLIAM SMITH	SUE SMITH	7/17/1937	-	-	-	-	-	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	-
123456789	WILLIAM SMITH	SUE SMITH	10/6/1954	-	-	-	-	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	-	OPEN	-
123456789	WILLIAM SMITH	SUE SMITH	3/23/1945	OPEN	CLOSED	CLOSED	CLOSED	CLOSED	OPEN	OPEN	OPEN	OPEN	OPEN	OPEN	OPEN	-	OPEN	CLOSED

[1] *This measure may have multiple occurrences based on the number of discharges that occurred during the measure year. Status is* ***OPEN*** *if at least one occurrence remains open.*

HEDIS® & Incentive Support

Addressing Gaps in Care

How to Close the Open Gaps

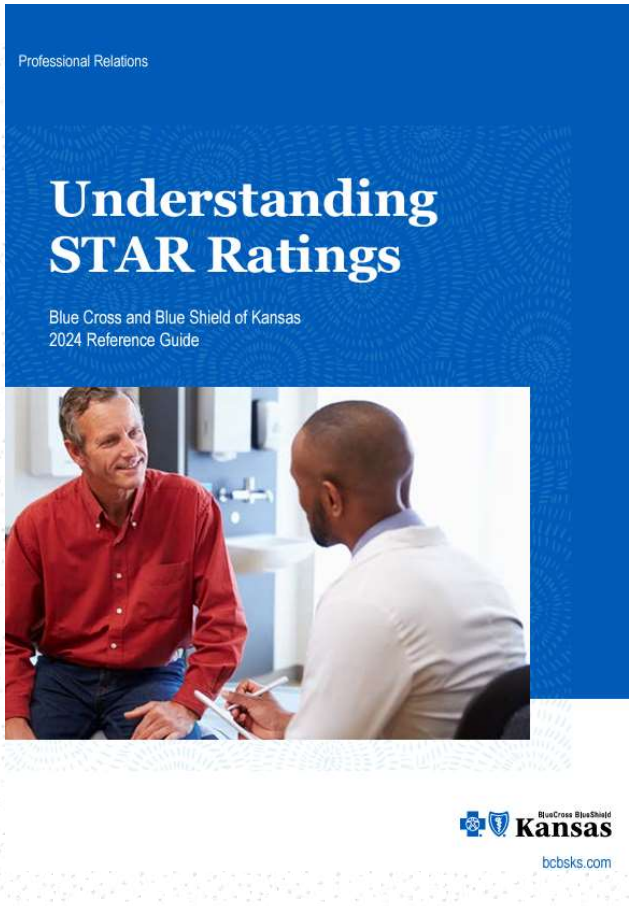
Claim Submission:

- Capturing the CPT or CPTII code supporting the HEDIS service
- Medicare Advantage Stars Tip Sheet / Stars Reference Manual
- 2024 HEDIS® Coding & Reference Guide
- Claims must be adjudicated by February 28, 2024

Record Submission:

- Submit the portion of the medical record that documents the service/test
- Include results and demographic information
- Must be submitted by December 16, 2024
- Fax: 833-505-2348, Attn: HEDIS Ops
- Email the patient's supporting documentation for the services(s) to KSOperations@advantasure.com
- Mail the patient's supporting documentation for the service(s) to:

Blue Cross and Blue Shield of Kansas
PO Box 260
Southfield, MI 48037-0260
Attn: HEDIS Ops, TC1402-E



Controlling Blood Pressure

Tips to Close Gaps in Care

Measure definition

Patients ages 18–85 in the measurement year who had a diagnosis of hypertension, and whose blood pressure was adequately controlled (<140/90 mm Hg) as of December 31 of the measurement year.

Information that patient medical records should include

Include all blood pressure readings and the dates they were obtained. The last blood pressure reading of the year will be used for HEDIS compliance determination.

Information that patient claims should include

Blood pressure CPT® II codes can be billed alone on a $0.01 claim or with an office visit. This includes telehealth, telephone, e-visit or virtual visit.

CPT® II code	Most recent systolic blood pressure
3074F	< 130 mm Hg
3075F	130–139 mm Hg
3077F	≥ 140 mm Hg
CPT® II code	Most recent diastolic blood pressure
3078F	< 80 mm Hg
3079F	80–89 mm Hg
3080F	≥ 90 mm Hg

Glycemic Status Assessment for Patients with Diabetes (GSD)

Tips to Close Gaps in Care

Measure definition

The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year:

- Glycemic Status < 8.0%
- Glycemic Status >= 9.0% lower rate indicates better performance

Information that patient medical records should include

Document the date and result of all glycemic status assessments (HbA1c or GMI). The last glycemic status assessment of the measurement year must be less than or equal to nine to show evidence of diabetes control.

Information that patient claims should include

HbA1c CPT® II are ***required to be billed on their own line, with a $0.01 charge, on any claim with an HbA1c (83036, 83037) billed with POS 11***. This includes telehealth, telephone, e-visit or virtual visit.

CPT® II code	Most recent HbA1c level
3044F	< 7%
3046F	> 9%
3051F	≥ 7% and < 8%
3052F	≥ 8% and ≤ 9%

Eye Exam for Patients with Diabetes (EED)

Tips to Close Gaps in Care

Definition: Patients ages 18−75 with a diagnosis of diabetes (Type 1 or Type 2) who had a retinal eye exam.

- Retinal or dilated eye exam by an eye care professional in the measurement year
- Negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year
- Bilateral eye enucleation any time during the patient's history

Information that patient medical records should include:

- Document the date of the eye exam, the retinopathy results, and eye care professional's name and credentials in the medical record to meet HEDIS compliance.
- Review the report and note if there are any abnormalities. If so, add the abnormalities to the patient's active problem list and indicate the necessary follow-up.
- Place the report in the patient's medical record.

For patient-reported retinal or dilated eye exams, document in the patient's medical record the date of the eye exam, the retinopathy result and the eye care professional who conducted the exam with credentials. If the name of the eye care professional is unknown, document that an optometrist or ophthalmologist conducted the exam.

CPT® II code	Retinal eye exam findings
2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; **with evidence of retinopathy**
2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; **without evidence of retinopathy**
CPT® code	**Automated eye exam with AI interpretation**
92229	Imaging of retina for detection or monitoring of disease; point-of-care automated analysis and report, unilateral or bilateral (interpreted by artificial intelligence)

Transitions of Care (TRC)

Measurement Definition

The percentage of discharges for patients 18 years of age or older, who had an acute or non-acute inpatient discharge on or between January 1 and December 1 of the measurement year and met each of the following components:

1. Notification of inpatient admission within 2 days
2. Receipt of discharge information within 2 days
3. Patient engagement after inpatient discharge within 30 days
4. Medication reconciliation post-discharge within 30 days

Exclusions

Patients are excluded if they:

- Received hospice care during the measurement year
- Are deceased during measurement year

Transitions of Care (TRC) – Notification of Inpatient Admission

Criteria

Receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 days total).

Outpatient medical record requirements

Must document the **date of receipt** and include at least one of the following criteria:

- Communication from inpatient provider, hospital staff or emergency department regarding admission (phone call, email, or fax). Referral to an emergency department does not meet criteria.
- Documentation that the patient's PCP or ongoing care provider admitted the patient, or a specialist admitted the patient and notified the patient's PCP.
- Communication through a health information exchange; an admission, discharge, and transfer alert system (ADT); or a shared electronic medical record.
- Documentation indicating the patient's PCP or ongoing care provider placed orders for tests and treatments during the member's inpatient stay.
- Documentation of a preadmission exam or a planned admission prior to the admit date. The exam must pertain to the specific admission event.

Transitions of Care (TRC) – Receipt of Discharge Information

Criteria

Receipt of discharge information on the day of the discharge through 2 days after the discharge (3 days total).

Outpatient medical record requirements

Must include **the date of receipt** and ALL of the following criteria:

- The practitioner responsible for the patient's care during the inpatient stay
- Procedures or treatment provided
- Diagnoses at discharge
- Current medication list
- Testing results, documentation of pending tests, or documentation of no tests pending
- Instructions for patient care post discharge

Transitions of Care (TRC) – Patient Engagement after Discharge

Criteria

Patient engagement provided within 30 days after discharge.

- May not occur on the date of discharge.

Outpatient medical record requirements

Must include the date of service and clinical notes for any of the following:

- An outpatient visit, including office visits and home visits.
- A telephone visit.
- A synchronous telehealth visit where real-time interaction occurred between the member and provider using audio and video communication.
- An e-visit or virtual check-in (asynchronous telehealth where two-way interaction, which was not in real-time, occurred between the member and provider).

NOTE: If the patient is unable to communicate with the practitioner, interaction between the patient's caregiver and the provider meets criteria.

Transitions of Care (TRC) – Medication Reconciliation Post-Discharge

Criteria

Medication reconciliation completed on the date of discharge through 30 days after discharge (31 total days).

NOTES:

Medication reconciliation must be conducted by a prescribing practitioner, clinical pharmacist, or registered nurse. Other staff members (MA or LPN) may document the medication reconciliation, but it must be signed off by the prescribing practitioner.

Medication reconciliation must be documented in the outpatient medical record, but an outpatient face-to-face visit isn't required.

Outpatient medical record requirements

Must include all three items described below:

1. Date the medication reconciliation was performed
2. Current medication list (at date of reconciliation)
3. Chart documentation of any one of the following:
    - Notation that the provider reconciled the current and discharge medications.
    - Notation that references the discharge medications (e.g., no changes in meds post discharge, same meds at discharge, discontinue all discharge meds, discharge meds reviewed).
    - Notation that the discharge medications were reviewed.
    - A discharge medication list with notation that both it and the current medications were reviewed on the same date of service.
    - Evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review. (Evidence includes notation of follow-up for "hospitalization," "admission", "discharge", or "inpatient stay".)
    - NOTE: Documentation of "post-op/surgery follow-up" alone is not considered sufficient chart evidence of a hospitalization.
    - Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record. Discharge summary must be dated and filed in the outpatient record within 30 days after discharge.
    - Notation that no medications were prescribed or ordered upon discharge.

Transitions of Care – Tips for Coding

CPT©/ CPT© II code	Description	Component
1111F	Discharge medications are reconciled with the current medication list in outpatient medical record. Can be billed alone since a face-to-face visit is not required.	4. Medication Reconciliation
98966 – 8, 98970 – 2, 98980 – 1, 99202 – 5, 99211 – 5, 99241 – 5, 99341 – 5, 99347 – 9, 99350, 99381 – 7, 99391 – 7, 99401 – 4, 99411 – 2, 99421 – 3, 99429, 99441 – 3, 99455 – 8, 99483	Outpatient and telehealth evaluation & management services	3. Patient engagement
99483	Assessment and care planning for a patient with cognitive impairment. Requires an array of assessments and evaluations, including medication reconciliation and review for high-risk medications, if applicable.	4. Medication Reconciliation
99495	Transitional care management that requires communication with the patient or caregiver within two business days of discharge (can be done by phone, email or in person) and decision-making of at least moderate complexity and a face-to-face (in-person or telehealth) visit within 14 days or discharge.	3. Patient engagement 4. Medication Reconciliation
99496	Transitional care management that requires communication with the patient or caregiver within two business days of discharge (can be done by phone, email or in person) and decision-making of at least high complexity and a face-to-face (in-person or telehealth) visit within 7 days of discharge.	3. Patient engagement 4. Medication Reconciliation

Visits with a practitioner can be with or without a telehealth modifier

Section Six

Pharmacy Outreach Programs

Tony Knutson, PharmD, BCPS

Statin Therapy for Patients with Cardiovascular Disease (SPC)

SPC

What is the measure?

Male patients ages 21-75 and female patients ages 40-75, who are identified as having clinical atherosclerotic CVD (ASCVD) and who were dispensed at least one high intensity or moderate intensity statin medication and who were at least 80% adherent for the remainder of the measurement year[1]

Why is it important?

ACC/AHA guidelines recommend moderate or high intensity statin for adults with established clinical ASCVD[2]

How can you impact?

Must be prescribed a moderate or high intensity statin to meet measure

Category	Medication	
High-intensity	• Atorvastatin 40–80 mg• • Amlodipine-atorvastatin 40–80 mg • Rosuvastatin 20–40 mg	• Ezetimibe-simvastatin 80 mg • Simvastatin 80 mg
Moderate-intensity	• Atorvastatin 10–20 mg • Amlodipine-atorvastatin 10–20 mg • Rosuvastatin 5–10 mg • Simvastatin 20–40 mg • Ezetimibe-simvastatin 20–40 mg	• Pravastatin 40–80 mg • Lovastatin 40 mg • Fluvastatin 40–80 mg • Pitavastatin 1-4mg

Statin Use in Persons with Diabetes (SUPD)

SUPD

What is the measure?

Diabetic patients ages 40-75 who were dispensed at least two diabetes medication fills and also received a statin medication fill at any time during the measurement year[1]

Why is it important?

- All Patients with diabetes are at higher risk of developing ASCVD[3]
- Cardiovascular disease (CVD) is major cause of morbidity and mortality in diabetes and in turn contributor of high cost for diabetes management[3]
- ADA and ACC/AHA guidelines recommend moderate to high intensity statins first line for patients with diabetes aged 40-75 for prevention of cardiovascular disease[2,3]
- Benefit of statin use in diabetes: primary and secondary prevention of CVD (~20%) and decreased mortality (~9%) [4]

How can you impact?

Prescribe statins to patients with diabetes when clinically appropriate

- Consider statin even with normal cholesterol levels for primary prevention
- Continue to discuss benefits of statins with patients

For patients experiencing adverse effects consider decreased dose/frequency or a more hydrophilic statin: rosuvastatin or pravastatin

SPC and SUPD Exclusions

To exclude patients unable to tolerate a statin, a claim with appropriate ICD-10 dose MUST be submitted ANNUALLY

Exclusion codes for SPC	
Condition	**ICD-10-CM Code**
Myalgia	M79.10–M79.12, M79.18
Myositis	M60.80–M60.819; M60.821–M60.829; M60.831–M60.839; M60.841–M60.849; M60.851–M60.859; M60.861–M60.869; M60.871–M60.879; M60.88–M60.9
Myopathy	G72.0, G72.2, G72.9
Rhabdomyolysis	M62.82

Exclusion codes for SUPD	
Condition	**ICD-10-CM Code**
Cirrhosis:	
Alcoholic cirrhosis of liver without ascites	K70.30
cirrhosis of liver with ascites	K70.31
Toxic liver disease with fibrosis and cirrhosis of liver	K71.7
Primary biliary cirrhosis	K74.3
Secondary biliary cirrhosis	K74.4
Alcoholic Biliary cirrhosis, unspecified	K74.5
Unspecified cirrhosis of liver	K74.60
Other cirrhosis of liver	K74.69

SPC and SUPD Exclusions, Continued

Exclusion codes for SUPD	
Condition	**ICD-10-CM Code**
End Stage Renal Disease/Dialysis:	
Chronic kidney disease, stage 5	N18.5
End stage renal disease	N18.6
Dependence on renal dialysis	Z99.2
Pregnancy and/or Lactation	Numerous > 1k
Polycystic Ovarian Syndrome	E28.2
Pre-diabetes	R73.03
Other abnormal blood glucose	R73.09
Adverse effect of antihyperlipidemic and antiarteriosclerotic drugs, initial encounter	T46.6X5A

*The condition the code refers to does not necessarily need to occur in the same year the code was billed. The member's medical chart should reflect 'history of'. These codes are intended to close Star measure gaps and do not apply to payment or reimbursement. Only the codes listed above will exclude the member from the SUPD measure.

Exclusion codes for SUPD	
Condition	**ICD-10-CM Code**
Rhabdomyolysis/myopathy/myositis*:	
Drug-induced myopathy	G72.0
Other specified myopathies	G72.89
Myopathy, unspecified	G72.9
Other myositis, unspecified site	M60.80
Other myositis, unspecified shoulder	M60.819
Other myositis, unspecified upper arm	M60.829
Other myositis, unspecified forearm	M60.839
Other myositis, unspecified hand	M60.849
Other myositis, unspecified thigh	M60.859
Other myositis, unspecified lower leg	M60.869
Other myositis, unspecified ankle and foot	M60.879
Myositis, unspecified	M60.9
Rhabdomyolysis	M62.82

Adherence: Diabetes, Hypertension and Cholesterol

Adherence

What is the measure?

Patients ages 18 and older with prescription for diabetes, hypertension or cholesterol who fill often enough to cover 80 percent or more of the time they are supposed to be taking medication, monitored by percent of days covered (PDC)[1]

Medications covered:

- Diabetes: Non-insulin diabetes medications
- Hypertension: ACE-inhibitors, Angiotensin receptor blockers (ARBs) and Direct Renin inhibitors (Aliskiren)
- Cholesterol: Statins

Why is it important?

Studies demonstrate improved outcomes for patients who are adherent to these medications[5]

Tips for Closing Gaps

Tips for Measure Success

1. Ensure patients fill through prescription drug benefit
   - Claims filled through discount programs and medication samples don't count
   - Gap closure is dependent on prescription drug event (PDE) data
2. Emphasize benefits of taking AND risks of not taking medications (benefits should outweigh risks)
3. Write prescriptions for 90-day supply AND with refills when tolerating and stable on regimen
4. Schedule follow-up visit within 30 days when prescribing new medications to assess effectiveness and tolerability
5. Encourage patients to utilize auto-fill programs and reminder tools (med box, calendar, alarm, etc)
6. At each visit ask patients open-ended questions about medication habits:
   - Side effects
   - How many doses missed
   - Financial barriers
   - Issues preventing refill of prescriptions

Why Mail Order and 90-Day Supply

1. Reducing member cost share
   - Drug cost is often a concern for patients
   - 90-day supply offer discounts on Tier 1 and 2 drugs through retail pharmacies
   - Mail order (prior to coverage gap and catastrophic coverage)
     - Tier 1 and 2 drugs are $0 copay
     - Tier 3 drugs have discounted 90-day supply
2. Convenience
   - Less trips to the pharmacy
   - Easier to sync medication fills
3. Improved adherence

2024 Member Drug Cost (Prior to coverage gap and catastrophic coverage)	
Retail	Mail Order
Tier 1: $3/30 DS $6/60 DS $6/90 DS	Tier 1: $0/30 DS $0/60 DS $0/90 DS
Tier 2: $5/30 DS $10/60 DS $10/90 DS	Tier 2: $0/30 DS $0/60 DS $0/90 DS
Tier 3: $45/30 DS $90/60 DS $135/90 DS	Tier 3: $45/30 DS $90/60 DS $90/90 DS
Tier 4: $100/30 DS $2000/60 DS $300/90 DS	Tier 4: $100/30 DS $200/60 DS $300/90 DS
Tier 5: 33% coinsurance/30 DS	Tier 5: 33% coinsurance/30 DS

Member savings opportunities

How Does Blue Cross Blue Shield of Kansas Help?

Member Outreach

1. Adherence calls
   - Phone call to patient to discuss possible barriers to adherence
   - Encourage patient to fill prescription regularly
2. Performance Network
   - Partner with local pharmacies to assist in closing gaps
3. Lettering campaigns
   - Identify specific patients that have open gaps
   - Sent to provider groups for appropriate coding or prescribing
4. Medication Therapy Management (MTM)
5. Health system and provider group partnerships
   - Current pilot program in Topeka
   - Consideration for other partnerships

Incentives Revisited

Financial Incentives for Meeting Measure Goals

Incentive Payout	Measure(s)
Quality Performance Measures	
$50	Uncontrolled Blood Pressure
$300	Annual Wellness Visit
Effectiveness of Care HEDIS Measures	
$50	Medication Adherence – Cholesterol*, Medication Adherence – Diabetes*, Medication Adherence – Hypertension*
$100	Breast Cancer Screening, Colorectal Cancer Screening, Eye Exam for Patients with Diabetes, Glycemic Status Assessment for Patients with Diabetes, Statin Therapy for patients with Cardiovascular Disease, Statin Use in Persons with Diabetes, Transitions of Care – Medication Reconciliation, Transitions of Care – Patient Engagement
$200	Controlling Blood Pressure

*Maximum potential Blue MA Stars Incentive of $1,500 per member

Medication Therapy Management (MTM)

MTM

How do patients qualify?

Must meet certain criteria

- Disease state
- Medication
- Financial

Automatic enrollment when criteria met

How can you help?

Encourage those qualifying to participate

2024 Qualifications

1. Have three or more of the following conditions:

- **Chronic Heart Failure (CHF)**
- **Diabetes**
- **High blood pressure**
- **High blood cholesterol**
- **Rheumatoid Arthritis (RA)**

AND

2. Take eight or more prescription drugs covered by Medicare Part D.

AND

3. Expect to spend $5,330 or more on prescription drugs covered by Medicare Part D in 2024.

AND/OR

4. Have an active coverage limitation for an opioid or frequently abused prescription drug as a result of a Drug Management Program.

MTM

What we offer?

Comprehensive medication review one-on-one with patient

Patient provided with summary letter including what was discussed, action plan, and up to date medication list

What can providers expect?

May receive intervention recommendations from pharmacist (faxed to provider clinic)

Recommended To-Do List

Prepared on: < *Insert CMR date* >

You can get the best results from your medications by completing the items on this **"To-Do List."**

Bring your **To-Do List** when you go to your doctor. And, share it with your family or caregivers.

My To-Do List

What we talked about:	**What I should do:**
< *Insert summary of discussion for topic 1* >	❑ < *Insert action item for topic 1* > ❑ < *Insert action item for topic 1* >

Medication List

Prepared on: < *Insert CMR date* >

Bring your Medication List when you go to the doctor, hospital, or emergency room. And, share it with your family or caregivers.

Note any changes to how you take your medications. Cross out medications when you no longer use them.

Medication	**How I take it**	**Why I use it**	**Prescriber**
< Insert generic name and brand name, strength, and dosage form for current/active medications >	*< Insert regimen, (e.g., 1 tablet by mouth daily), use of related devices, and supplemental instructions as appropriate >*	*< Insert indication or intended medical use >*	*< Insert prescriber name >*

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3. American Diabetes Association. 9. Cardiovascular Disease and Risk Management: Standards of Medical Care in Diabetes-2018. Diabetes Care. 2018; 41(Suppl1):S86-S104.
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BlueCross BlueShield Kansas

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Section Seven

Patient Experience STARS Measures

Health Outcomes Survey (HOS)

Member perception Star Measures

Why is the HOS important?

The goal of the HOS is to gather clinically meaningful health status data from Medicare Advantage patients to support quality improvement activities, monitor health plan performance and improve the health of this patient population.

What is my impact?

Providers can significantly impact how patients assess their health care experience in response to HOS questions.

CMS has contracted with NCQA to support the standardized administration of the HOS and HOS-Modified surveys. https://www.hosonline.org/en/program-overview/

Healthcare Effectiveness Data and Information Set. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Improving/Maintaining Physical Health

In general, would you say your health is: Excellent; Very good; Good; Fair; Poor?

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

- Moderate activities such as moving a table, pushing a vacuum cleaner, bowling, or playing golf
- Climbing several flights of stairs

During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

Tips for success

- ✓ Develop a plan with your patients to take steps to improve physical health
- ✓ Ask patients if they have pain, and if so, is it affecting their ability to complete daily activities? Ask what goals the patient has, then identify ways to improve the patient's pain.
- ✓ Determine if your patient could benefit from a consultation with a pain specialist, rheumatologist or other specialist.

Monitoring Physical Activity

In the past 12 months, did:

- You talk with a doctor or other health care provider about your level of exercise or physical activity?
- A doctor or other health care provider advise you to start, increase or maintain your level of exercise or physical activity?

- ✓ Talk to patients about their physical activity and the health benefits of staying active. Studies show that having patients fill out a questionnaire is not enough to gauge their activity level. Show interest in ensuring patients remain active.
- ✓ Develop a plan with your patient to take steps to start or increase physical activity. Offer suggestions based on the patient's physical ability, interests, and access. Schedule a check-in to discuss progress on this plan.
- ✓ Refer patients with limited mobility to physical therapy to learn safe and effective exercises.

Improving or Maintaining Mental Health

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

Tips for Success:

- ✓ Ask patients if they have any trouble holding their urine. If yes, ask additional questions.
- ✓ Communicate that urinary leakage problems can be common as we grow older, but there are treatments that can help. Discuss potential treatment options such as behavioral therapy, exercises, medications, medical devices and surgery.
- ✓ Use informational brochures and materials as discussion starters for this sensitive topic.

Reducing the Risk of Falling

In the past 12 months, did you talk with your doctor or other health provider about falling or problems with balance or walking?

Did you fall in the past 12 months?

In the past 12 months, have you had a problem with balance or walking?

Has your doctor or health provider done anything to help you prevent falls or treat problems with balance or walking?

- ✓ Promote exercise, physical therapy and strengthening and balance activities (tai chi, yoga).
- ✓ Review medications for any that increase fall risk.
- ✓ Discuss home safety tips such as removing trip hazards, installing handrails and using nightlights.
- ✓ Suggest the use of a cane or walker, if needed.
- ✓ Recommend a vision or hearing test.

Consumer Assessment of Healthcare Provider and Systems (CAHPS®)

Member perception Star Measures

Why is the CAHPS important?

Research shows that a positive health care experience for patients is associated with positive clinical outcomes and better business outcomes, including lower medical malpractice risk and less employee turnover.

What is my impact?

Providers significantly impact how patients assess their health care experience.

Overall Rating of Health Care Quality

Using any number between zero and 10, where zero is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last six months?

Getting Appointments and Care Quickly

- How often did you see the person you came to see within 15 minutes of your appointment time?
- When you needed care right away, how often did you get care as soon as you needed?
- How often did you get an appointment for routine care as soon as you needed?

Tips for Success

- ✓Survey your patients, asking how you can improve their health care experience
- ✓Create a patient council for regular feedback
- ✓Remember that every patient contact has an impact on patient perception

- ✓ Patients are more tolerant of delays if they know the reason for the delay.
- ✓ Consider implementing advanced access scheduling, offering telehealth, scheduling routine visits and follow-ups in advance.

Care Coordination

- How often did your doc have your medical records or other information about your care?
- When your personal doctor ordered a blood test, X-ray, or other test for you, how often did someone from your personal doctor's office follow up to give you those results?
- How often did you and your personal doctor talk about all the prescription medicines you were taking?

Getting Needed Care

In the last six months:

- How often did you get an appointment to see a specialist as soon as you needed?
- How often was it easy to get the care, tests or treatment you needed?

Tips for Success

- ✓Administer the flu shot as soon as it's available each fall
- ✓Eliminate barriers to access by offering multiple locations and options for patients to get their shot (walk-in, flu shot clinics, flu shots at every appointment for eligible patients)
- ✓Promote flu shots through website, patient portal , and phone greeting

- ✓ Set realistic expectations
- ✓ When applicable, share how you can help secure an appointment sooner if you have an established relationship with the specialist
- ✓ Explain why certain test or treatments are ordered
- ✓ Patient ownership

Section Eight

Health Equity & Social Determinants of Health

CMS National Quality Strategy

Advance health equity and whole-person care

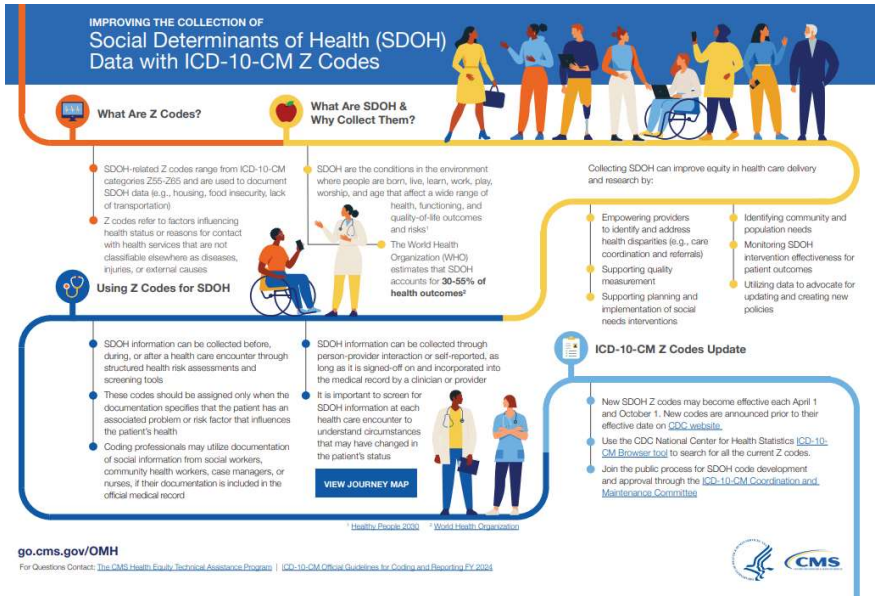
- Aligns quality goals across CMS programs (MA, Medicare, Medicaid, CHIP, ACA)
- Prioritize the use of Universal Foundation Measures
- Commit to improving health care safety and reducing harm
- Advance health equity to improve health outcomes and eliminate disparities

References:

https://www.cms.gov/medicare/quality/meaningful-measures-initiative/cms-quality-strategy

https://www.cms.gov/files/document/quality-motion-cms-national-quality-strategy.pdf

Health Equity and Social Determinants of Health



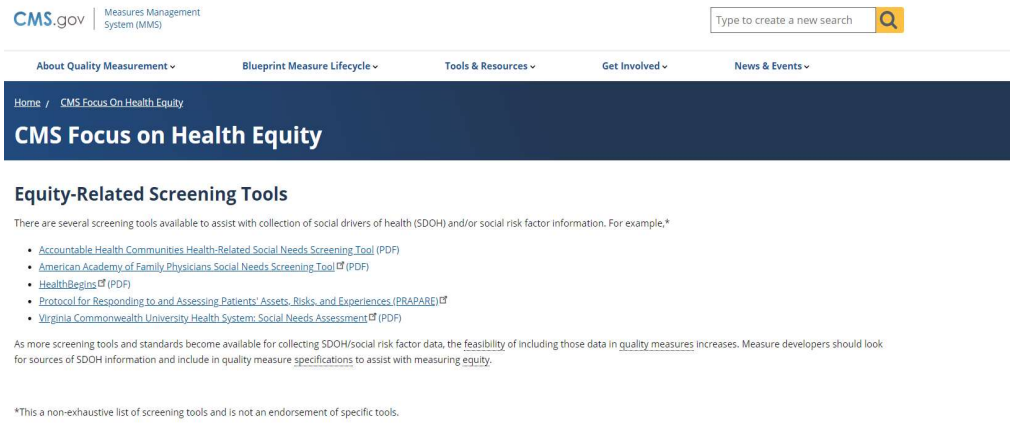
BCBSKS is committed to addressing disparities in care by recognizing and improving environmental and societal conditions and advancing health equity and inclusion.

SDoH codes in ICD-10-CM Chapter 21:

- Z55 Problems related to education and literacy
- Z56 Problems related to employment and unemployment
- Z57 Occupational exposure to risk factors
- Z58 Problems related to physical environment
- Z59 Problems related to housing and economic circumstances
- Z60 Problems related to social environment
- Z62 Problems related to upbringing
- Z63 Problems related to primary support group, including family circumstances
- Z64 Problems related to certain psychosocial circumstances
- Z65 Problems related to other psychosocial circumstances

Social Needs Screening

- EMR Integration
- CMS Listed Resources



CMS.gov | Measures Management System (MMS)

Type to create a new search

About Quality Measurement | Blueprint Measure Lifecycle | Tools & Resources | Get Involved | News & Events

Home / CMS Focus On Health Equity

CMS Focus on Health Equity

Equity-Related Screening Tools

There are several screening tools available to assist with collection of social drivers of health (SDOH) and/or social risk factor information. For example,*

- Accountable Health Communities Health-Related Social Needs Screening Tool (PDF)
- American Academy of Family Physicians Social Needs Screening Tool (PDF)
- HealthBegins (PDF)
- Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)
- Virginia Commonwealth University Health System: Social Needs Assessment (PDF)

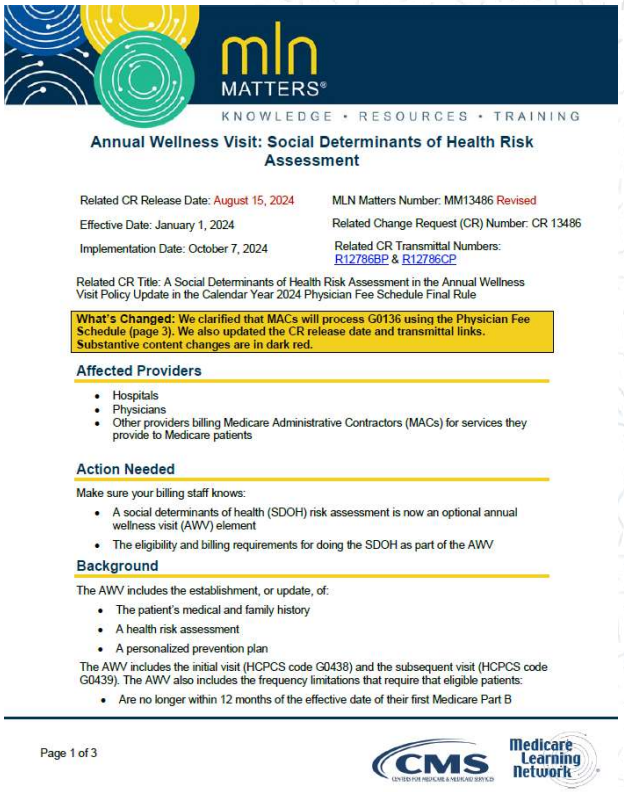
As more screening tools and standards become available for collecting SDOH/social risk factor data, the feasibility of including those data in quality measures increases. Measure developers should look for sources of SDOH information and include in quality measure specifications to assist with measuring equity.

*This a non-exhaustive list of screening tools and is not an endorsement of specific tools.

https://mmshub.cms.gov/about-quality/quality-at-CMS/goals/cms-focus-on-health-equity/equity-related-screening-tools

https://mmshub.cms.gov/about-quality/quality-at-CMS/quality/cms-focus-on-health-equity

https://www.cms.gov/files/document/mm13486-annual-wellness-visit-social-determinants-health-risk-assessment.pdf



mln MATTERS®

KNOWLEDGE • RESOURCES • TRAINING

Annual Wellness Visit: Social Determinants of Health Risk Assessment

Related CR Release Date: August 15, 2024
Effective Date: January 1, 2024
Implementation Date: October 7, 2024

MLN Matters Number: MM13486 Revised
Related Change Request (CR) Number: CR 13486
Related CR Transmittal Numbers: R12786BP & R12786CP

Related CR Title: A Social Determinants of Health Risk Assessment in the Annual Wellness Visit Policy Update in the Calendar Year 2024 Physician Fee Schedule Final Rule

What's Changed: We clarified that MACs will process G0136 using the Physician Fee Schedule (page 3). We also updated the CR release date and transmittal links. Substantive content changes are in dark red.

Affected Providers

- Hospitals
- Physicians
- Other providers billing Medicare Administrative Contractors (MACs) for services they provide to Medicare patients

Action Needed

Make sure your billing staff knows:

- A social determinants of health (SDOH) risk assessment is now an optional annual wellness visit (AWV) element
- The eligibility and billing requirements for doing the SDOH as part of the AWV

Background

The AWV includes the establishment, or update, of:

- The patient's medical and family history
- A health risk assessment
- A personalized prevention plan

The AWV includes the initial visit (HCPCS code G0438) and the subsequent visit (HCPCS code G0439). The AWV also includes the frequency limitations that require that eligible patients:

- Are no longer within 12 months of the effective date of their first Medicare Part B

Page 1 of 3

CMS Medicare Learning Network

Section Nine

Risk Adjustment & Patient Assessment Forms

What is risk adjustment?

Predicting Health Care Costs

As defined by Centers for Medicare and Medicaid Services (CMS), risk adjustment (RA) predicts the future health care expenditures of individuals based on diagnoses and demographics. This model predicts health care costs based on the actuarial risk of enrollees which is established based on chronic conditions, age, race, socioeconomic status, and gender. The goal of risk adjustment is to mitigate the impact to insurers with higher-risk populations and help manage health insurance premiums annually

Who benefits and Why is it important?

It Benefits Plans, Providers AND Patients!

- Plans benefit because the goal of risk adjustment is to mitigate the impact to plans with higher-risk populations and help manage health insurance premiums annually
- Providers benefits include improved understanding of patient health status, incentives for completing PAF forms
- Patients benefit as providers and plans will have adequate health information on patients therefore can tailor certain care for them and there is more emphasis on preventative service which leads to better health outcomes

How it works?

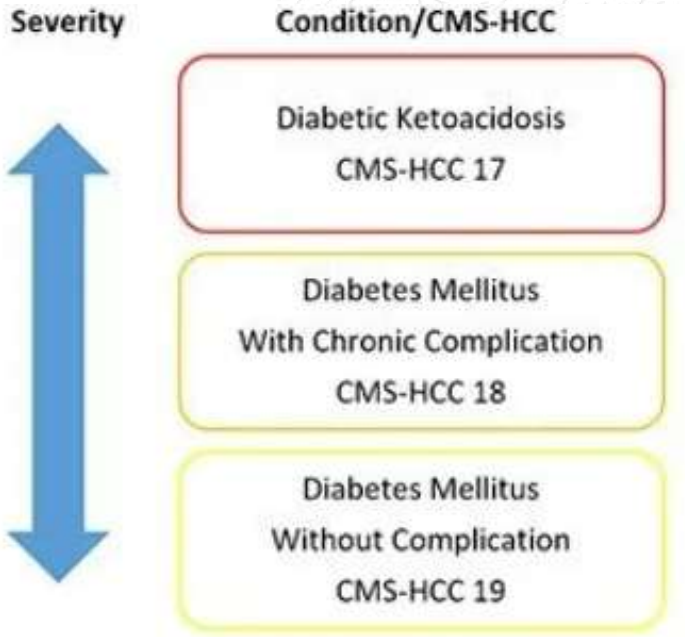
MA Risk Adjustment in Practice

- John and Jane enrolled in Blue Cross and Blue Shield of Kansas Medicare Advantage plans
- CMS Provides a premium to BCBSKS to provide healthcare services for John and Jane
- CMS premium to BCBSKS is not the same for the two

Hierarchical Condition Categories

CMS-HCC based MRA model

- Prospective cost prediction
- Groupings of similar or related diagnosis
- Most significant chronic and acute conditions are included
- Each condition category is assigned a numeric HCC code
- HCC Code assigned a score



Risk Adjustment Factor (RAF)

Risk Adjustment Documentation and Coding Accuracy

- Demographics
- Valid provider signature
- Code to the highest level of specificity
- Accurately document combination codes
- Document co-existing conditions
- Don’t code unconfirmed diagnoses
- Use ‘History of’ codes
- Standard Acronyms/Abbreviations

MEAT Guidelines

Documentation to support ICD-10-CM assignment

- M = Monitoring by ordering or reference labs, imaging studies or other tests
- E = Evaluation with a targeted part of the physical examination specific to a certain diagnosis
- A = Assessment of the status, progression or severity of the diagnosis
- T= Treatment with medication, surgical intervention or lifestyle modification. *Treatment also includes referral to a specialist for consultation or management.*

Examples of MEAT include:

Monitoring

Ordering diagnostic tests:
- "HgbA1c ordered"
- "Chest X-ray ordered"
- "Checking PT/INR"

Referencing test results
- "CT scan of abdomen shows stable AAA"
- "EKG reveals atrial fibrillation"
- "U/A negative for protein"

Evaluation

Targeted physical exam for specific diagnosis:
- PVD – "Dorsalis pedis and posterior tibial pulses are weak"
- Diabetic neuropathy – "Monofilament exam showed decreased sensation"
- COPD – "Diminished air entry with expiratory wheezing on lung exam"

MEAT

Assessment

Status:
- "Stable," "unstable"
- "Well controlled," "poorly controlled," "out of control"

Progression:
- "Worsening," "improving," "unchanged"
- "Doing better," "progressing as expected"

Severity:
- "Mild," "moderate," "severe"
- "Minimal," "significant," "extreme"

Treatment

Medication:
- "Cardizem added," "increased dose of Lasix"
- "Refilled metformin," "continue statins"

Surgical intervention:
- "Femoral artery stented"
- "Malignant melanoma excised"

Lifestyle modification:
- "Diet and exercise discussed"
- "Encouraged to attend AA meetings"

Referral to specialist:
- "Ophthalmologist managing exudative macular degeneration"
- "Follow up with nephrology for secondary hyperparathyroidism"

Documenting conditions managed by specialists

Documentation tips for primary care providers

- Addressing a condition in the medical record refers to the documentation of any monitoring, evaluation, assessment or treatment of the condition, including referral of the patient to a specialist.
- Managing a condition implies being directly involved in medical decision-making, workup, or treatment of the condition
- For MA, as long as the diagnosis is addressed by an approved provider during a face-to-face or A/V telehealth visit, and is supported by documentation, the corresponding ICD-10-CM code can be submitted on a claim.

The CMS Risk Adjustment Participant Guide states, *"Physicians should code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care, treatment or management."*

What is external EMR Access?

- Risk adjustment audits occur throughout the year with requests ranging from 1 patient to over 500 patients
  - External EMR access is a way for the risk adjustment team to access and abstract necessary records to fulfill the audit request without requiring any work from a facilities HIM/ medical records staff
  - Setting up access is a simple process that includes the manager of risk adjustment partnering with the facilities office manager or IT staff to obtain access
  - Have further questions about external EMR access, please contact:

    Jamie Schnacker, Manager Retrospective Risk Adjustment
    Phone: 785-291-6796
    Email: Jamie.Schnacker@bcbsks.com

Changes in 2025

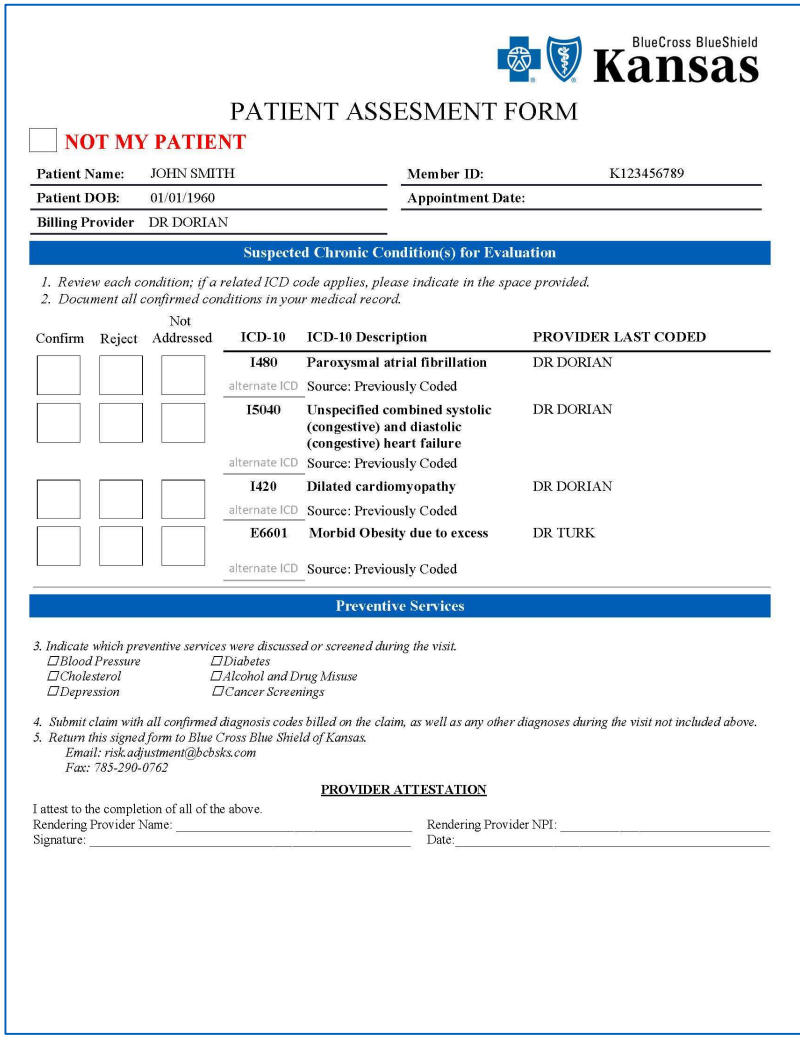
- Patient Assessment Forms will be replacing CDI Alerts
- Rolling out Provider Scorecards

Patient Assessment Form

Better documentation results in better care for patients

The Patient Assessment Form helps providers:

- Capture their patient's actual severity of illness in the medical record
- Improve risk score accuracy and medical record documentation
- Reduce the chance of a risk adjustment data validation audit
- Increase Star (quality) measure performance
- Earn a $100 incentive for addressing at least one historical or suspected condition



BlueCross BlueShield Kansas

PATIENT ASSESMENT FORM

☐ NOT MY PATIENT

Patient Name:	JOHN SMITH	**Member ID:**	K123456789
Patient DOB:	01/01/1960	**Appointment Date:**	
Billing Provider	DR DORIAN		

Suspected Chronic Condition(s) for Evaluation

1. Review each condition; if a related ICD code applies, please indicate in the space provided.
2. Document all confirmed conditions in your medical record.

Confirm	Reject	Not Addressed	ICD-10	ICD-10 Description	PROVIDER LAST CODED
☐	☐	☐	**I480**	**Paroxysmal atrial fibrillation**	DR DORIAN
			alternate ICD	Source: Previously Coded	
☐	☐	☐	**I5040**	**Unspecified combined systolic (congestive) and diastolic (congestive) heart failure**	DR DORIAN
			alternate ICD	Source: Previously Coded	
☐	☐	☐	**I420**	**Dilated cardiomyopathy**	DR DORIAN
			alternate ICD	Source: Previously Coded	
☐	☐	☐	**E6601**	**Morbid Obesity due to excess**	DR TURK
			alternate ICD	Source: Previously Coded	

Preventive Services

3. Indicate which preventive services were discussed or screened during the visit.
☐ *Blood Pressure* ☐ *Diabetes*
☐ *Cholesterol* ☐ *Alcohol and Drug Misuse*
☐ *Depression* ☐ *Cancer Screenings*

4. Submit claim with all confirmed diagnosis codes billed on the claim, as well as any other diagnoses during the visit not included above.
5. Return this signed form to Blue Cross Blue Shield of Kansas.
Email: risk.adjustment@bcbsks.com
Fax: 785-290-0762

PROVIDER ATTESTATION

I attest to the completion of all of the above.
Rendering Provider Name: _____ Rendering Provider NPI: _____
Signature: _____ Date: _____

New PAF form vs Old CDI Alert

BlueCross BlueShield Kansas

PATIENT ASSESMENT FORM

☐ **NOT MY PATIENT**

Patient Name:	JOHN SMITH	**Member ID:**	K123456789
Patient DOB:	01/01/1960	**Appointment Date:**	
Billing Provider	DR DORIAN		

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			alternate ICD	Source: Previously Coded	
☐	☐	☐	I5040	Unspecified combined systolic (congestive) and diastolic (congestive) heart failure	DR DORIAN
			alternate ICD	Source: Previously Coded	
☐	☐	☐	I420	Dilated cardiomyopathy	DR DORIAN
			alternate ICD	Source: Previously Coded	
☐	☐	☐	E6601	Morbid Obesity due to excess	DR TURK
			alternate ICD	Source: Previously Coded	

Preventive Services

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Fax: 785-290-0762

PROVIDER ATTESTATION

I attest to the completion of all of the above.
Rendering Provider Name: _____ Rendering Provider NPI: _____
Signature: _____ Date: _____

BlueCross BlueShield Kansas **Clinical Documentation Improvement Alert**

Please use this alert as a guide during the face-to-face or telehealth (audio and visual component) patient visit. Exercise your independent clinical judgment when addressing these conditions; the fact that a question is asked does not imply that any particular answer is desired or expected. Please note that the alert may not include all conditions or quality measures that exist for this patient.

Select Yes if the documentation from this visit supports the diagnosis indicated, select No if the patient does not have the condition indicated, select Not Addressed if the condition was not addressed during this visit. You can refer to the Reference Tool for further guidance on documentation and coding of specific conditions.

Submit the alert with the office visit notes from the same date of service.

Provider Name: Dr. John Smith Location: Provider Office ABC
Member Name: Jane Doe Member DOB: 3/13/1948 Member ID: 123456 Appointment Date: 2/15/2022

Confirmation of Diagnosis- The following diagnoses have been submitted for this patient in prior claims or supplemental data sent to the payor.

Yes	_ No	_ Not Addressed	I700 Atherosclerosis of aorta
Yes	_ No	X Not Addressed	F3342 Major depressive disorder, recurrent, in full remission
Yes	X No	_ Not Addressed	E1122 DM type 2 with diabetic chronic kidney disease

Clinical Documentation Improvement Opportunities- Based on medical record review of clinical indicators, we identified the below clinical documentation opportunities.

Yes	_ No	_ Not Addressed	Obstructive sleep apnea (OSA) noted; please consider screening echocardiogram for pulmonary hypertension given documented risk factor
Yes	_ No	_ Not Addressed	The following criteria for morbid obesity were noted: BMI >35 with comorbidities of HTN and DM; please assess for morbid obesity and document if appropriate
Yes	X No	_ Not Addressed	Patient has chronic asthma, on inhalers; please consider screening with PFT for asthma with chronic obstruction

Star Measure Gap Closure- Based on claims data, the following Star Measure Gaps need to be addressed during the patient visit. Please perform the steps indicated below and mark the box.

Test ordered / Patient referred / Service/Test completed	_ Not Performed	Colorectal Cancer Screening: Patient needs colorectal cancer screening. Please refer patient for colonoscopy for flex sig, or order FOBT or Cologuard test. If already done, please document DOS and place a copy of the report in the chart.
Test ordered / Service/Test completed	X Not Performed	Breast Cancer Screening: Patient needs mammogram. Please order test. If already done, please document DOS and place a copy of report in chart.

Provider Tax ID: 1234567 Contact Name: Sue Jones
Provider Signature: John Smith M.D. Date: 2/15/2022

2023

PAF Incentive

Earn $100 per attributed patient by participating

Requirements:

- The patient must have Blue Medicare Advantage covered and be attributed to the provider
- Patients must have at least one open diagnosis gap identified from January 1 through September 30
- Open Diagnosis gaps addressed before December 31 during a face-to-face or audio and visual telehealth visit
- Alerts completed and returned with the office visit notes within 14 days of the patient visit

For more information, contact your BCBSKS Professional Relations Medicare Advantage Representative

Provider Scorecards for Risk Adjustment

- Starting in 2025 we will be sharing with providers Risk Adjustment Provider Scorecards
- Scorecards will be delivered via provider portal Availity.
- Metrics will include but not limited to: AWV count, RAF scores, Recapture Rates, % of PAFs completed

Section Ten

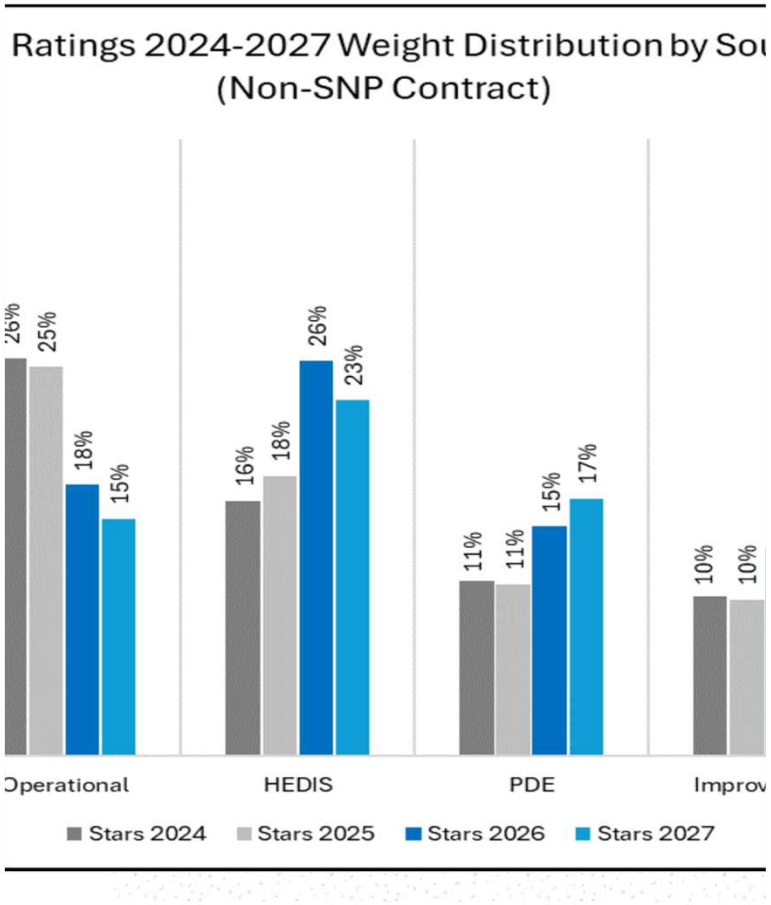
2025 CMS Updates and What's ahead for MA

MA Stars Ratings Changes Ahead

Measures and Ratings Changes Addressed in 2025 Final Rule

2025 Measurement Year / 2027 Stars Ratings:

- New Measures:
  - Concurrent Use of Opioids and Benzodiazepines (COB)
  - Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults (ACH)
- Weight Changes:
  - Improving and Maintaining Physical Health (From 1x to 3x)
  - Improving and Maintaining Mental Health (From 1x to 3x)
- Measure Updates
  - COL-E (45-49 age group added to measure)
  - SPC exclusion for patients with a history of statin intolerance
  - Revised codes for Diabetic Retinal Eye Exam (EED)



2025 BCBSKS Blue MA Enhancements

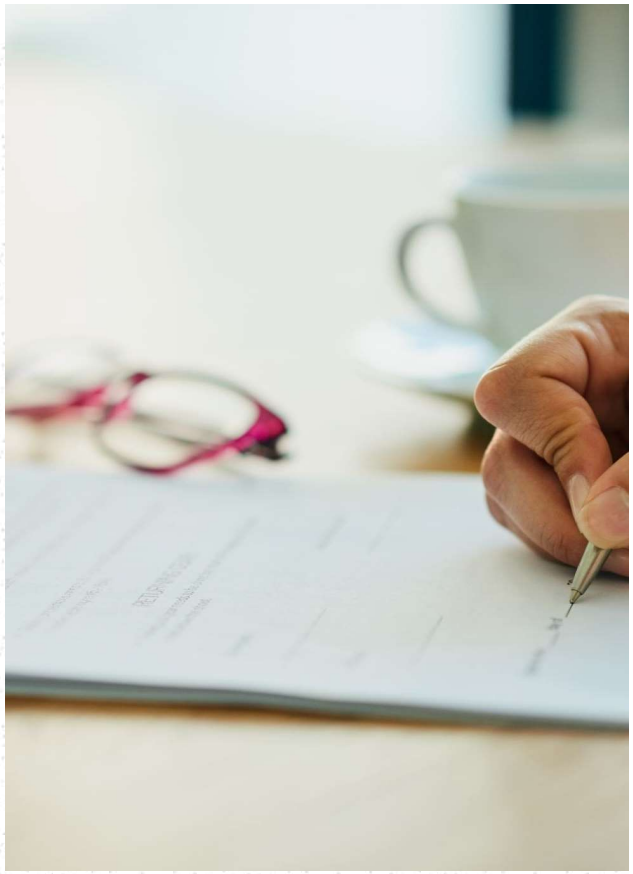
- MA Provider Scorecards moving to BlueAccess®
- New CSC and Appeals contacts
- Risk Adjustment Programs
- Pharmacy/MTM resources

Conclusion

Who to Contact + Q&A

Credentialing and Contracting

Preferred Blue Medicare Advantage Network



MA Agreeement

Becoming a Preferred Blue MA provider is easy, reach you to your Professional Relations Representative

Benefits of Blue

The value in contracting

The insurer Kansans trust with their health for over 80 years.

- Local member contracts
- Opportunity to earn additional revenue
- Detailed claim-payment information
- Direct payment
- Dedicated field staff
- Electronic remittance advice
- Access to Provider Network Services
- Liaison committees
- Provider directories
- Workshops

Who to Contact

Provider Services and Requests for Organization Determinations			
	Phone	**Fax**	**Hours of Operation**
Provider Services	800-240-0577	800-976-2794	8 a.m. – 6 p.m. Monday-Friday
Host Member Claim Inquiries	800-432-3990	785-290-0711	7 a.m. – 4:30 p.m. Monday- Friday
Prior Authorization			
	Phone	**Fax/Web Address**	**Hours of Operation**
Prior Authorization Program	800-325-6201	877-218-9089	8 a.m. – 6 p.m. Monday-Friday
Lucet Behavioral Health	877-589-1635	https://webpass.ndbh.com/	
Utilization Management and Care Transition			
	Phone	**Fax**	**Hours of Operation**
Utilization Management/ Care Transition	800-325-6201	877-218-9089	8 a.m. – 6 p.m. Monday-Friday
After Hours	800-325-6201	877-218-9089	24 hours Saturday-Sunday

Professional Relations

- Patrick Artzer, CPC – Medicare Advantage Professional Relations Representative
- Provider Network Services

Institutional Relations

Mark Decker – Government Programs Provider Consultant

TRIWEST HEALTHCARE ALLIANCE®

TRICARE

BCBSKS has partnered with TriWest to serve our military families utilizing our provider network.

Professional TRICARE Representative

Emily Emmot, CPC

Emily.Emmot@bcbsks.com

785-291-8819

Thank you, Providers!

Questions?

bcbsks.com

Patrick Artzer, CPC

Professional Relations

Medicare Advantage Representative

785-291-6289

Patrick.Artzer@bcbsks.com