Medicare Advantage Update

OCTOBER 2020

BlueCross BlueShield Nebraska

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Medicare Advantage Update contains up-to-date information for providers about Medicare Advantage plans with Blue Cross and Blue Shield of Nebraska (BCBSNE).

We encourage you to print a copy of this Update and keep it with your BCBSNE Medicare Advantage Core HMO and Choice HMO-POS Provider Manual. To request permission to reprint this material for any other purpose, please send an email to the editor, Cassie Wade, at Cassandra.Wade@NebraskaBlue.com.

Please refer to your provider manual often. You may view it at **NebraskaBlue.com/MA-Manual**.

To view past issues of Medicare Advantage Update, visit **NebraskaBlue.com/MA-Update**.

Blue Cross and Blue Shield of Nebraska is an Independent Licensee of the Blue Cross and Blue Shield Association.

Informational Medicare seminars available for Annual Enrollment Period

Blue Cross and Blue Shield of Nebraska's (BCBSNE) Medicare team offers free virtual and in-person seminars during the Annual Enrollment Period (AEP) to help people find a plan that fits their health care needs.

Enrollment began Thursday, Oct. 15 and will run through Monday, Dec. 7. BCBSNE's Medicare Advantage Prescription Drug plans expanded into 42 additional counties with new benefits for 2021, including:

- Telehealth services
- 24/7 nurse line
- Acupuncture
- Increased dental allowance

Continued benefits include:

- Eyewear
- Hearing aid allowance
- Nationwide coverage
- And more

To help your patients connect with our experts and reserve their spot in one of our informational seminars, have them call 888-320-0184.

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The information in this newsletter applies to Blue Cross and Blue Shield of Nebraska's Medicare Advantage Core HMO and Medicare Advantage Choice HMO-POS plans. The information in these articles is not intended to be legal advice and, as such, it remains the provider's responsibility to ensure that all coding and documentation is done in accordance with applicable state and federal laws and regulations. HEDIS®, which stands for Healthcare Effectiveness Data and Information Set, is a registered trademark of the National Committee for Quality Assurance (NCQA).

Medication reconciliation post-discharge

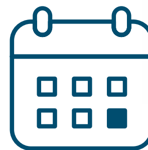
is critical to patient safety and care coordination efforts

Medication reconciliation is the process of comparing a patient's post-hospital medication list to their pre-hospital medication list. Changes in the medication list should be reviewed and documented. This process ensures awareness of the most accurate list of patient medications, allergies and adverse drug reactions.

View the **medication reconciliation post-discharge tip sheet** to learn more about when the process should be completed, information to include in a patient's record, CPT codes to include in claims and tips for talking with patients about this important topic.

Step Therapy

will soon be required for some medical benefit drugs

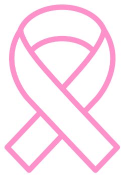


Starting Jan. 1, 2021, Medicare Advantage plans will require step therapy for certain Part B drugs, according to a Centers for Medicare & Medicaid Services (CMS) memo.

Step therapy is treatment for a medical condition that starts with the most preferred drug therapy and progresses to other drug therapies only if necessary. The goal of step therapy is to encourage better clinical decision-making.

Examples of drugs that require step therapy are:

- Botox® for migraines and overactive bladder
- Eylea®, Lucentis® and Beovu® for neovascular age-related macular edema
- Prolia® for osteoporosis



Active vs. historical
cancer diagnosis in risk adjustment

Since almost all diagnosed active cancers are risk adjustable, it is imperative that cancer is coded accurately, and documentation contains as much detail as possible.

Health care professionals should be especially mindful when reporting higher-risk active cancer diagnoses. Use specificity when documenting the member's progression, response to their current treatment plan and side effects while also noting what extent of treatment remains.

A primary malignancy or active cancer code should be reported until all treatment is completed. If the member is undergoing any form of treatment for a neoplasm, such as surgical excision (if possible), current long-term chemotherapy or radiation therapy, the active cancer code should be reported. If treatment is not an option or the member has opted to decline treatment, the active cancer should still be coded.

Historical cancer diagnosis for coding purposes indicates that a member had a previous diagnosis of cancer and currently has no evidence of malignancy and treatment, such as surgery or therapy has been completed successfully, and the member is now disease free. In this circumstance, it is appropriate to report a personal history of malignant neoplasm code using category Z85, indicating the member has completed treatment.

Of course, there are a few exceptions to the rule...

Members who are status-post treatment of breast cancer and currently prescribed a hormone therapy drug for prophylactic treatment/chemoprevention, should be reported as a personal history of breast cancer unless otherwise noted. Documentation should clearly reflect that hormonal therapy is being used for prophylactic reasons, including the expected length of time the member will be taking the medication. Some hormonal therapy drugs are also used to treat metastatic breast cancer, causing a need for definitive, accurate and clear documentation to distinguish specific treatment type.

For members diagnosed with breast cancer on current adjuvant therapy or immune targeted therapy, the more detailed documentation, the better. In most cases, the cancer should be coded as active.

October is Breast Cancer Awareness Month and a good reminder of how important it is as a health care professional to discuss the importance of annual well woman exams, Pap tests and mammograms with female members.

This article is dedicated to those we have known and lost, those we know who continue to battle this horrible disease and those who we are so fortunate to call survivors.

Review BCBSNE's 2020 CAHPS survey results

Patient's experiences and their perception of health care quality make up a significant portion of a health plan's overall Medicare Star Rating score. Plans collect clinically-meaningful patient-recorded outcomes and health status data using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. This survey can help payors and providers improve on any uncovered deficiencies. BCBSNE contracts with an external company, SPH Analytics, to conduct the survey every year. SPH mailed 800 surveys to our Medicare Advantage members in 2020 and had a 47.6% response rate.

BCBSNE and our providers received scores greater than the national average for:

Survey measure	National Average	BCBSNE 2019	BCBSNE 2020
Getting needed care	90.1%	92.7%	95.6%
Getting appointments and care quickly	85.2%	86.2%	90.1%
How well doctors communicate	96.4%	96.9%	98.1%

Sample questions in these areas:

- In the last six months, how often was it easy to get the care, tests or treatment you needed?
- In the last six months, how often did you get an appointment to see a specialist as soon as you needed?
- In the last six months, how often did your personal doctor explain things in a way that was easy to understand?

We have room to improve in a couple of areas:

Survey measure	National Average	BCBSNE 2019	BCBSNE 2020
Advised to quit smoking	84.3%	84.8%	73.5%
How members rate their drug plan	66.9%	51.9%	60.4%

Sample questions in these areas:

- In the last six months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider?
- Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your prescription drug plan?

Two reasons to improve CAHPS scores:

1. Improved patient experiences and quality outcomes lead to healthier and happier patients.
2. Medicare Star Ratings affect payments to Medicare providers and managed care organizations. CAHPS survey results contribute heavily to these overall Star Ratings.

Please encourage your patients to complete these surveys if they receive them. Together, we can work toward ensuring members receive the care they need when they need it.

Sharing our

2020 HEDIS results

Healthcare Effectiveness Data and Information Set (HEDIS®)[i] is a set of standardized performance measures updated and published annually by the National Committee for Quality Assurance (NCQA). Most U.S. health plans use HEDIS to measure performance on important aspects of care and service. HEDIS is designed to provide purchasers and consumers with the information they need to reliably compare the performance of health care plans. CMS uses HEDIS data to monitor health plan performance in multiple areas, including quality of care and service.

HEDIS results can help us guide effective and efficient management of patient care by allowing us to continually monitor patient health, prevent complications and identify any additional issues that may potentially develop. Final HEDIS rates are typically reported to CMS once a year. Through HEDIS, BCBSNE is accountable for the timeliness and quality of health care services delivered to our members.

Due to the COVID-19 pandemic, which impacted the retrieval of records, CMS released guidance in March allowing plans to suspend their medical record retrieval project and report 2019 results for 2020. BCBSNE has done so below, making our results for 2019 and 2020 as follows:

Measure	Medicare Advantage 2019 - 2020
Comprehensive Diabetes Care – Eye Exam Performed (CDC)	63.38%
Comprehensive Diabetes Care – HbA1c Control <8.0% (CDC)	71.79%
Comprehensive Diabetes Care Hemoglobin A1c Testing (CDC)	95.73%
Comprehensive Diabetes Care – Medical Attention for Nephropathy (CDC)	94.87%
*Comprehensive Diabetes Care – Poor Control <9% (CDC)	15.38%
Comprehensive Diabetes Care – Blood Pressure Control (CDC)	74.36%
Medication Reconciliation Post – Discharge (MRP)	53.30%

*Lower number is better

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

Improving diabetic patient health while reducing medical record review requests

The HEDIS comprehensive diabetes care measure provides a picture of the clinical management of diabetic patients. All comprehensive diabetes care measures are used for HEDIS reporting, which CMS uses as a star rating measure to drive improvements in patient health.

Patients with diabetes require consistent medical care and monitoring to reduce the risk of severe complications and improve health outcomes. Interventions to improve diabetes outcomes go beyond glycemic control. That is why the comprehensive diabetes care composite measure includes HbA1c control, retinal eye exams, medical attention for nephropathy and blood pressure control.

View the **Comprehensive Diabetes Care tip sheet** to learn more about what is included in the measure, new exclusions, including advanced illness and frailty, and ways you can close gaps in care for patients with diabetes. The tip sheet also covers required medical record documentation and claims coding to reduce the need for medical record reviews.

Additional codes will soon require preauthorizations

Beginning Jan. 1, 2021, additional codes will be added to preauthorizations for the following services for BCBSNE Medicare Advantage members:

- Facility-based sleep studies
- Mobile cardiac monitoring
- Spinal fusion
- Cosmetic and reconstructive surgery
- Genetic testing
- Non-emergency ambulance and air ambulance

Providers should contact BCBSNE to obtain an authorization before scheduling or performing any of the above services.

Authorization requests can be submitted via fax at 866-422-5120 or by calling 877-399-1671, Monday through Friday from 8 a.m. to 4:30 p.m. CT.

If you have questions or would like more information about the articles in this newsletter, please contact your Provider Executive at **877-435-7258** 8 a.m. to 4:30 p.m. CT, Monday through Friday.