PRIORITIZE MEMBER EXPERIENCE

Emphasizing the need to improve experience for Medicare Advantage (MA) members, Centers for Medicare & Medicaid Services (CMS) made significant changes to the MA Star Ratings formula beginning in 2021 that will affect the 2023 Star Ratings score.

The most visible changes to the MA Star Ratings formula are in the annual Consumer Assessment of Healthcare Providers and Systems® (CAHPS) surveys. CAHPS survey results had an assigned weight of 2 in 2020, and CMS doubled the weight to 4 in 2021. Blue MA Members' experience reported through the CAHPS surveys will now account for close to one third (32%) of the MA plan's overall Star Ratings!

Through the CAHPS surveys questions, beneficiaries (or caregivers) provide answers and rate their overall (positive or negative) experience of their interactions with providers (e.g., hospitals, post-acute care, home health, PCP, etc.) and their Blue MA plan. These questions focus on areas:

1. How EASY is it to ACCESS CARE
2. COMMUNICATION from PROVIDERS
3. How well beneficiaries UNDERSTAND MEDICATION INFORMATION

The health plans and providers must work collaboratively to achieve high performance in each of these areas. Without this end-to-end commitment from both, those that we care for will not receive the most positive healthcare experience. Through our actions together, we reinforce attention to our members is our priority and empower their engagement with providers for more collaborative healthcare decision making.

The first two articles in this Q1 Provider Post spotlight actions to improve members' understanding of their medications. Please let us know if you implemented any of the suggestions and the impact it had on your patients' care and experience.

IMPROVE ADHERENCE, HEALTH OUTCOMES, & PATIENT EXPERIENCE BY IMPROVING MEDICATION EDUCATION

Patients' understanding of why they have been prescribed a medication and how to obtain or access it by using their MA plan benefits is critical. This results in more favorable perceptions and greater appreciation of those interactions along their health care journey. More importantly, it leads to better health outcomes.

Adverse events after hospitalization occur in one (20%) in five patients. Two-thirds (66%) of these adverse events are directly related to issues with their medications. The most effective way to combat this shockingly high percentage is to improve our approach to *education* about the prescribed medication and *evaluate* understanding and barriers to adherence.

Take opportunities with visits and phone calls (to or from) your office to educate your patients on their medications. On the following page, there are five key components with medication discussions to better engage and support compliance with prescribed treatment.

KEY COMPONENTS WITH MEDICATION DISCUSSIONS

1. NAME

Educate:

- ❖ Use the name of the medication as you ordered it to minimize confusion between what they heard and what they will see on the pharmacy bottle.

Evaluate:

- ➢ *What is the name of medication we just talked about?*

2. DOSAGE

Educate:

- ❖ Use the same dosage that will be on the pharmacy bottle.

Evaluate:

- ➢ *Can you tell me the number of pills you need to take?*
- ➢ *What is the strength (dosage) of each pill?*

3. PURPOSE

Educate:

- ❖ Provide brief and clear explanation about what the medication ordered treats and how it will help.

Evaluate:

- ➢ *Can you please help me understand why I prescribed this medication?*

4. SIDE EFFECTS

Educate:

- ❖ Begin with the most common side effects and move into the more serious. When educating about medication, reinforce that you are partners in their care and frequently encourage them to the office to report any concerns.

Evaluate:

- ➢ *What are the side effects that do not worry you too much?*
- ➢ *What are side effects that scare you?*

5. ADHERENCE

Educate:

- ❖ Provide information about how long they need to take the medication before the positive effects of feeling better or seeing changes in lab work/diagnostics should take. If you know that a negative side effect is common with the medication but resolves after a certain amount of days, share that information. Encourage patients to call their insurances' customer service number if they run into any problems with getting the medication.

Evaluate:

- ➢ *How long will it take for us to see if this medication is helping you or not?*
- ➢ *What should you do if start feeling worse?*
- ➢ *Should you stop taking the medication because you feel a lot better and do not think you need it anymore?*
- ➢ *Are you worried about getting or paying for your medication?*
- ➢ *Would a 90-day prescription make it easier for you to keep on your medication?*
- ➢ *What should you do if you do not know what your insurance covers or need help with getting the medication?*

EDUCATE. EVALUATE. REPEAT.

DECREASE RISK OF READMISSIONS

Transitions of Care (TRC) Measure

To decrease likelihood of a patient's readmission to inpatient service, timely outreach, contact with the member, and medication reconciliation within 30 days post-discharge decreases likelihood of readmission and supports smooth transition from acute care. Transitions of Care (TRC) Measure monitors the percentage of discharges after each inpatient facility* stay between January 1, 2021 and December 1, 2021 for members age 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).

** When the patient transfers from one inpatient facility to another (e.g., inpatient hospital to skilled nursing facility (SNF), acute rehabilitation, or long-term acute care hospitals (LTACHs)), the date of discharge is from the final inpatient facility. (e.g., upon discharge from SNF).*
**Exclusion: Hospice care*

To meet this measure, documentation of all four actions, outlined below, must come from the same outpatient medical record.

NOTIFICATION OF INPATIENT ADMISSION:

Documentation in the outpatient medical record of receipt of notification of inpatient admission on the date of admission through two days after admission (total of three days).

Evidence of receipt of admission notification (time/date stamped) on the day of admission through two days after admission to comply with measure.

EXAMPLES

- *Notification of Inpatient Admission Examples Include:*
- *Phone call, email, fax, or other communication between providers or staff from the emergency department or inpatient facility providers*
- *Communication about the admission to the member's PCP or ongoing care provider through a health information exchange (HIE), an automated admission alert from Admissions, Discharges, and Transfers (ADT system, or a shared electronic medical record (EMR)).*
- *Indication that the PCP or ongoing care provider placed orders for tests and treatments during the member's inpatient stay or completed a preadmission exam prior to elective inpatient stay.*

RECEIPT OF DISCHARGE INFORMATION:

Documentation in the outpatient medical record of receipt of notification of discharge information on the date of discharge through two days after admission (total of three days).

Evidence of receipt of discharge information (time/date stamped) on the day of discharge through two days after admission to comply with measure.

EXAMPLES

- *Discharge information may be included in a discharge summary, summary of care, or in structured fields in an electronic health record.*

PATIENT ENGAGEMENT AFTER INPATIENT DISCHARGE:

Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days *after* discharge date (total of 30 days). Patient on day of discharge is not included.

Evidence of patient engagement (time/date stamped) on the day after discharge through thirty days following to comply with measure.

EXAMPLES

- *Documentation of outpatient visit (including office and home visits), telephone visit, synchronous telehealth visit, e-visit, or virtual check-in.*

  Note: If the member is not able to communicate with provider or provider's staff, the interaction can be with the member's caregiver.

MEDICATION RECONCILIATION POST-DISCHARGE

Evidence of medication reconciliation (time/date stamped) provided on the day of discharge through thirty days after discharge (total of 31 days) with documentation of medication reconciliation done by a prescribing practitioner, clinical pharmacist, or registered nurse OR documentation of transitional care management.

Medication reconciliation is a review where the discharge medications are reconciled with the most recent outpatient medication list.

Evidence of medication reconciliation (time/date stamped) on the day after discharge through thirty days following to comply with measure *and* name and licensure of who completed the review.

USE CORRECT COMBINATION CODES FOR HYPERTENSIVE CONDITIONS

A guideline that is often overlooked in documenting and coding is the proper use of combination codes such as, hypertensive heart disease or hypertensive kidney disease. A combination code is one in which two diagnoses are combined into one code or when a diagnosis is associated with a manifestation or complication.

When documenting conditions caused by hypertension, it is best to use descriptive words that link the conditions. However, in ICD-10-CM guidelines, a causal relationship between hypertension and heart involvement and between hypertension and kidney involvement are assumed without the use of words that link such as "with" or "due to".

Below is a breakdown of combining hypertension with heart disease and renal manifestations.

Example: Patient is discharged with final diagnosis of Congestive Heart Failure (CHF) (I50.9) and a secondary diagnosis of hypertension (I10). This would be coded as **I11.0** – Hypertensive heart disease with heart failure along with the actual code for CHF **I50.9**.

Example: Patient is discharged with final diagnosis of hypertension (I10). Past medical history includes Chronic Kidney Disease (CKD), stage 4 (N18.4) and Chronic diastolic Congestive Heart Failure (I50.32) both of which are being monitored. This would be coded as **I13.0 -** Hypertensive

heart and chronic kidney disease with heart failure and stage 1-4 CKD, or unspecified CKD along with Chronic diastolic Congestive Heart Failure - **I50.32** and CKD stage 4 - **N18.4.**

Note: If provider specifies a different cause of the heart failure or kidney disease, then each condition would be coded separately and not linked with combination codes.

Using combination codes gives a more accurate description of patients' health risk and disease burden and should be properly documented for precise coding.

MEET CLAIMS SUBMISSION & TIMELY FILING REQUIREMENTS

CLAIMS SUBMISSION

Claims must be submitted using standard Medicare guidelines. Blue Medicare Advantage accepts CMS 1500 or UB-04's and electronically submitted claims. Refer to the Electronic Claims section for further information.

Contracted providers should seek electronic claims solutions as indicated in their Health Plan contract. **If the provider must bill on paper, they should follow standard CMS claims submission requirements including submission of the Blue Medicare Advantage Member ID as it appears on the member ID card.**

The provider is responsible for ensuring accurate and complete data for submission. When filing claims for secondary coverage, be sure to include the Explanation of Benefits from the primary insurer or the claim will be denied.

Blue Medicare Advantage processes all clean claims within the 30-day CMS required standards. Status checks can be performed via our Provider Portal. Blue Medicare Advantage permits submission of claims for up to 6 months from the date of service per provider contract.

TIMELY FILING REQUIREMENTS

Providers must adhere to the following timeline filing requirements:

SERVICING PROVIDER	INITIAL CLAIM	ADJUSTMENT, REVIEW, & DETERMINATION	APPEAL
• **Participating** • **In-Network** • **Blue Medicare Advantage Contracted**	180 days from date of service	365 days from date of service	Not allowed unless it involves a *pre-service request*
• **Non-Participating** • **Out of Network** • **Not Blue Medicare Advantage Contracted**	12 months from date of service	365 days from date claim processed	365 days from *initial* organizational determination