YOUR GUIDE TO PROGRAMS AND REWARDS

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Resilience During the Pandemic

As we start the third year of the COVID-19 pandemic, we should think about ways to help our patients through these difficult times. When the pandemic began, we thought we were undergoing changes that might last a few weeks to a couple of months. Now we're in our third or fourth wave, and realize that we're not going to return to our pre-pandemic normal soon, or maybe ever.

Fortunately, in the past couple of decades, people who've endured great stressors have been studied to determine what successful strategies for resilience are common to them. In **The Resilience Prescription**, Dennis Charney, MD, President for Academic Affairs at Icahn School of Medicine at Mt. Sinai, has summarized these strategies that can be useful for us as well as our patients. There are 10 items on the prescription, but no one masters all of them. People have natural talents in some, and they can improve their skills in others.

Our patients have a history of resilience, but aren't often in touch with that history. We can help them inventory the strategies they're already using, and help point them to ways to strengthen a few more strategies for resilience.

Kelly Askins, MD

Behavioral Health Medical Director

BlueCare Tennessee

The Resilience Rx

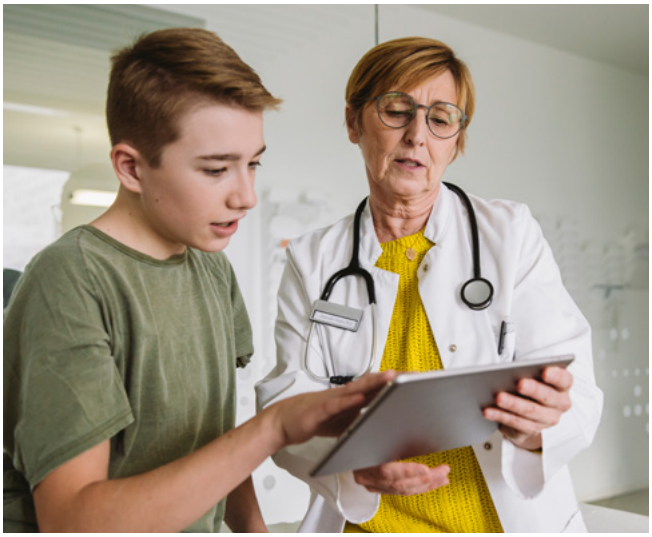
1. Positive Attitude
2. Cognitive Flexibility Through Cognitive Reappraisal
3. Embrace a Personal Moral Compass
4. Find a Resilient Role Model
5. Face Your Fears
6. Develop Active Coping Skills
7. Establish and Nurture a Supportive Social Network
8. Attend to Physical Well-Being
9. Train Regularly and Rigorously in Multiple Areas (Emotional Intelligence, Moral Integrity, Physical Endurance)
10. Recognize, Utilize and Foster Signature Strengths

A Successful Approach to Human Papillomavirus (HPV) Vaccines

How Old Harding Pediatric Associates Achieves High Compliance Rate

Getting adolescent patients vaccinated for HPV is a struggle for many pediatric groups. In fact, it's typical to see an average compliance rate of 30% for the HPV vaccine for many groups across the state of Tennessee. However, Old Harding Pediatric Associates has had better-than-average success and is consistently achieving around 60%.

Sarah Ligon, CEO of Old Harding Pediatrics, said their physicians follow the recommendations of the American Academy of Pediatrics (AAP), so it was something they knew they were going to focus on as soon as the vaccine was available. "We follow all AAP recommendations. So, there was no question about it," Ligon said.



Over time, the group realized they had varying degrees and methods of how physicians were encouraging parents to have their children vaccinated. They began to look more closely at their rates. Ligon said, "That's when we held a physician meeting and talked about the importance of the HPV vaccine. We had to make sure that everyone was on the same page. We talked through any hesitations until all the physicians in the group were behind the approach we agreed to take." Even then, Ligon said they didn't see a great increase in their rates until they completely changed the way they talk about the vaccine to parents.

"Your number one goal should be to have all your physicians on the same page."

Sarah Ligon

CEO, OLD HARDING PEDIATRIC ASSOCIATES

Adopting an Opt-Out Approach

The next step was developing an educational campaign for the physicians and staff. Because the nursing staff spends a lot of time with parents and patients before they see their physician, they had an important role to play. Ligon said they emphasized the importance of leaving personal commentary out of the HPV discussion. If parents have questions or concerns, that should be directed to the physician. "Our nurses are very involved in the visit. It starts with them and ends with the physician. We trained them to walk in and say, 'This is what you're getting today. Here's some information to read. We need your signature here.' We use an opt-out approach, not an opt-in. We've also added literature in each exam room that covers common misinformation about the vaccine. Once we incorporated this process, our numbers completely changed,"she said.

Old Harding Pediatrics has also changed their narrative concerning the HPV vaccine. Instead of talking about the sexually transmitted disease (STD) aspect, they focus on cancer prevention for later in life.

Physician recommendation had the single greatest effect on parents' uptake of HPV vaccines for their children, supported by evidence from over 20 studies.*

Follow-up for the Second Vaccine

Ligon said while there's a push to look for opportunities for needed vaccines at every office visit, it can be over-looked during a sick visit. It's an area they're still working on. What does work well for them is the use of electronic medical records (EMR). After each office visit, the staff enters a recall in the EMR system with the due date for the second vaccine. When it comes up, the appointment staff calls to schedule the appointment.

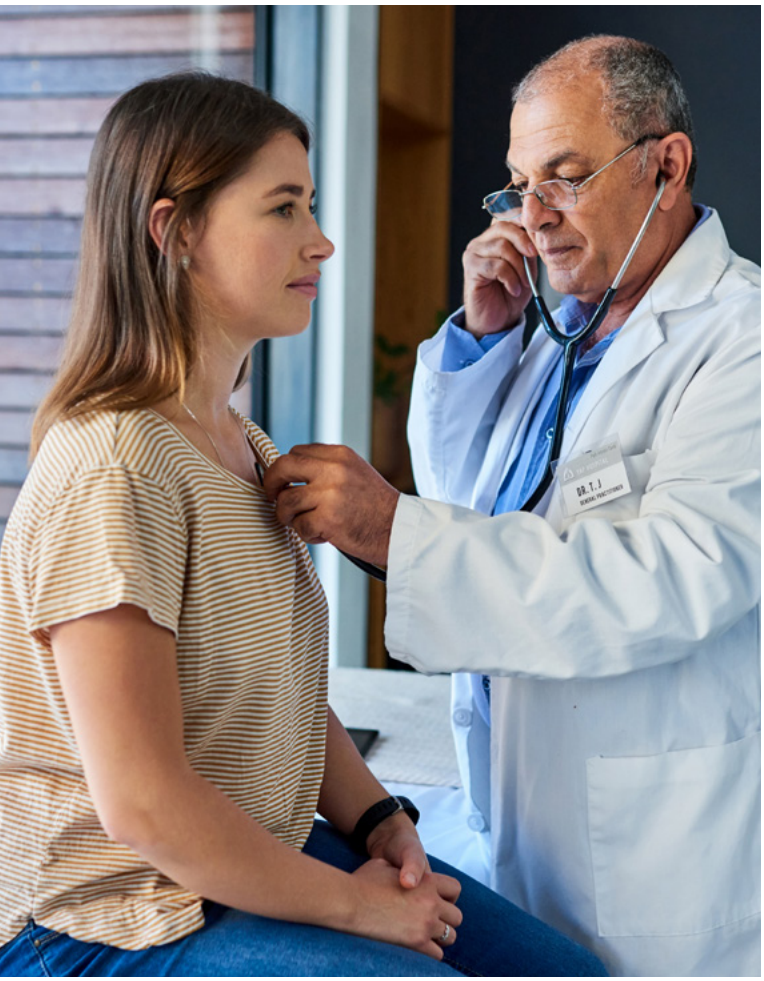
* Newman, P., Logie, C., Lacombe-Duncan, A., Baiden, P., & Suchon, T. (2018). Parents' uptake of human papillomavirus vaccines for their children: a systemic review and meta-analysis of observational studies. BMJ Open, 8(4).

A Clinical Focus

Improving Your Patients' Perception of Care and Communication

Each year, the National Committee for Quality Assurance (NCQA) and The Centers for Medicare & Medicaid Services (CMS) survey your patients, including randomly selected BlueCross members, to evaluate the care and services you provide. The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, conducted by an outside entity, measures the patient's perception of the consumer care, coordination of care, and the communication they receive from both you and BlueCross.

As a provider, your interactions have a direct impact on your patients' responses to the CAHPS survey. In the sections below, you'll find suggestions for ways to improve a patient's perception of the care and communication they receive.



Consumer Care

- Explain why you're referring the patient to a specialist.
- Help coordinate referral scheduling and records transfer instead of assigning these tasks to the patient. Educate patients on timeframes for obtaining specialist appointments according to their symptoms, and discuss potential appointment delays.
- When patients need a specialist, suggest more than one option.
- If you know patients received specialty care, discuss their visit and the treatment plan they received at their next clinic or telehealth visit.

Coordination of Care

- Organize and share patient care activities and information among everyone involved in a patient's care to support your goal of delivering high-quality, high-value health care.
- Clearly communicate the reason for a referral to a specialist, and provide information on tests that have already been completed. Establish how and when the results will be communicated, and request the earlier available appointment time. If needed, request patients be put on a "call list" to be contacted if an earlier appointment time opens up.
- Establish follow-up processes (fax, EMR, portal, or phone) with specialists to be sure you receive results within a specific timeframe after the patient's appointment.
- Standardize your referral tracking process. Set up a system for tracking outstanding referrals once a week, and follow up to be sure care is moving forward. Monitor the response times of referral partners and provide feedback when the response times aren't satisfactory. Implement reminder systems to follow up with patients to confirm they've attended specialist appointments.

Communication

- Before each patient visit, review the reason for the visit and determine if you need to follow up on any health issues or concerns from previous visits, including lab results and referrals to specialists.
- Establish a system to follow up on each diagnostic or lab result. Set appropriate timeframes for communicating the results (i.e., five days for normal results, 24 hours for stat results). Tell patients about your established timeframes and ask patients how they would prefer to receive test results, then provide as requested.
- Ensure you're aware of the patient's needs and preferences, and that these are communicated at the right time to the right people.
- Prepare a written summary and plan for the patient before they leave.
- Follow up with patients by phone after visits to answer questions and troubleshoot any challenges with filling prescriptions, completing lab work or attending specialist visits.

CAHPS Survey Questions

- In the last 6 months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care?
- In the last 6 months, 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?
- In the last 6 months, when your personal doctor ordered a blood test, X-ray or other test for you, how often did you get those results as soon as you needed them?
- In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?
- In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?
- In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?

Trends and Changes Related to Colorectal Cancer Screenings

Investing in healthier communities is a priority for BlueCross. By working together, we can make an impact on the health of your patients by focusing on a very important screening.

In 2020, the American Cancer Society estimated more than 147,000 people would be diagnosed with colon or rectal cancer and 53,000 would die from this disease. The numbers are growing rapidly for those under the age of 50. From March through May of 2020, there was an 86% decrease in colorectal cancer screenings nationally, due to COVID-19. This downturn in screenings caused 18,000 delayed or missed diagnoses in just a few months – which could result in an additional 5,000 deaths.

Proposed Changes to the Colorectal Cancer Screening Measure

The Healthcare Effectiveness Data and Information Set (HEDIS®) helps us measure many aspects of care, including colorectal cancer screening. The current Colorectal Cancer Screening (COL, COL-E*) measure focuses on members ages 50-75 who had the appropriate COL screening.

The NCQA proposes adding members ages 45-49 to the measure and adding the Medicaid product line for reporting in measurement year (MY) 2022. These proposed changes would align the measure with recent updated guideline recommendations for screening from the U.S. Preventive Services Task Force and other national organizations.

Support and Tips for Success

We support your efforts by raising awareness with clinical reminders, patient education, and preventive screening opportunities that encourage colorectal cancer screenings. We know you're committed to providing quality care, so we're also including the following information and tips to help you be as successful as possible.

A **Screening Colonoscopy** is a preventive procedure used to detect abnormalities that could lead to colorectal polyps and cancer when no gastrointestinal symptoms are present. In some cases, when the doctor is conducting this procedure, it may be necessary to remove a polyp discovered during the screening. Under most benefit plans, this would still be considered a preventive colonoscopy screening, as long as the physician uses the appropriate diagnosis code. A **Screening Colonoscopy is covered at 100% in most benefit plans**.

A **Diagnostic Colonoscopy** is a procedure used by doctors to look for a specific abnormality when the patient is considered at-risk for colorectal polyps or cancer and/or displays gastrointestinal symptoms such as a change in bowel habits, rectal bleeding, cramping or abdominal pain.

Sample codes for screening colonoscopy benefits

- Colorectal cancer screening; colonoscopy on individual at high risk – G0105
- Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk – G0121
- Colonoscopy during the measurement year or the nine years prior – CPT® 44388-44394,44397, 44401-44408, 45355, 45378-45393, 45398 (every 10 years)

Sample CPT® codes

While colonoscopy is the gold standard, the measure will close with any of the following screening types:

- Flexible sigmoidoscopy during the measurement year or the four years prior: 45330-45335, 45337-45342, 45346,45347, 45349-45350 (every five years).
- CT colonography during the measurement year or the four years prior: 74261-74263 (every five years).

Access to colonoscopy remains challenging in many settings, and some individuals are reluctant to seek medical care. An attractive solution has become at-home screening using FIT Tests.

- FIT-DNA Test can be performed during the measurement year or the two years prior: 81528 (every three years). This is different from the plain FIT testing – this testing uses DNA.
- Fecal occult blood testing (FOBT), including fecal immunochemical testing (FIT): 82270, 82274 requires only one stool sample (annually). If using guaiac testing, three samples are required.

Documentation in the medical record must include a note indicating the date the colorectal cancer screening was performed. A result isn't required if the documentation is clearly part of the patient's medical history section of the record. If this isn't clear, the result or findings must also be present. This ensures that the screening was performed and not just ordered.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Sources

Colorectal Cancer Alliance Executive Summary-2020-21 Colorectal Cancer Screening During COVID-19 and Beyond

NCQA Public Comment on proposed HEDIS Changes measurement year 2022

Healthy Futures Start with Well-Child Care

The coronavirus pandemic has affected rates for essential preventive services, including well-child checkups. As we enter another year of the pandemic, consider these tips to help make promoting and delivering well-child care easier for your practice.

Adjust Your Schedule

Seeing patients in the evenings one or two nights a week or opening for a few hours on the weekend may make it easier for busy families to visit your office. If you're thinking about extending your office hours, talk with families to see what times may be most convenient for them to attend appointments.

When you see patients outside of normal office hours, you may be able to receive reimbursement for both providing the service and delivering it after hours. Claims for these visits should include the appropriate service code, CPT® code 99050, to indicate the service was performed outside of regular office hours, and place of service 11.

Make Outreach Easier

Several tools are available to help your office track well-care rates and contact patients who are past due for services. Some EMR systems allow you to set up automatic reminders that help you see more patients and reduce missed visits. Others track when children are past due for a visit, allowing you to follow up with a phone call or letter.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) section of our Quality Care Rewards application in Availity® also provides valuable information, including a detailed list of your patients who are due for a well-care visit. To view a list of patients who need preventive care, follow these steps:

1. Select the **BlueCare EPSDT** program from the **Contract** view of the QCR.
2. Click the Excel® **Export** icon to see a detailed record of patients who are past due for their EPSDT exams. We update this list monthly, and it includes the date of the last wellness check and the number of missed EPSDT visits.

You can find an up-to-date list for your Commercial patients who are due for their well-care visits within the QCR portal, as well.

Use Telehealth When Appropriate

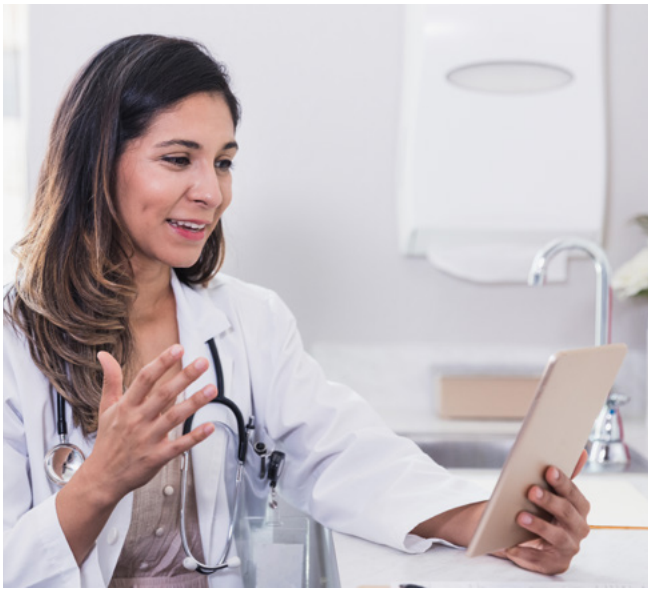
We continue to cover telehealth visits for applicable services. Consider performing certain components of the EPSDT visit, or the well-care visit, through telehealth, and then, scheduling a follow-up visit for in-person services, like vaccines. You can learn more about our telehealth coverage by reviewing the **BlueCare Tennessee Provider FAQs** on **BCBSTupdates.com**, or the **Commercial Telehealth Guide** on **provider.bcbst.com**.

Making the Most of Telehealth for the Treatment of Opioid Use Disorder and Other Mental Health Conditions

As more people stayed home throughout the pandemic, the use of telehealth drastically increased, including treatment of patients with Opioid Use Disorder (OUD). Telehealth can offer treatment to those who wouldn't otherwise access it, which increases positive outcomes. Surveys of multiple Medication Assisted Treatment (MAT) agencies have shown that patients are more compliant with treatment when using telehealth*. And that's significant because increased compliance can lead to higher rates of successful recovery.

* Responses gathered between February and April 2021 during the BlueCross annual BESMART Provider Quality Reviews.

Telehealth has proven to help patients overcome certain barriers they've had to getting care. Patients who've had a difficult time attending appointments due to competing priorities, such as employment and caregiving responsibilities, were more easily able to fit in time to attend a telehealth appointment. The same is true for those who lacked reliable transportation. Similarly, patients who are sick or have symptoms of illness can dial in for a telehealth appointment and limit face-to-face interaction.



Here are some best practices for using telehealth services with your patients:

- Tell patients about telehealth policies and informed consent.
- Have a plan for when:
  - the technology fails or there's a lack of access.
  - the patient has low technology literacy or a disability.
  - there's a language barrier.
- Establish a policy for emergency situations during telehealth, including knowing the patient's location in case you need to send emergency response.
- Be ready to adjust to the potential lack of nonverbal cues from the patient.
- Ask clarifying questions to mitigate misunderstandings.
- Use video rather than telephone whenever the technology is available.
- Have the member establish a quiet area to be able to focus and have privacy during the telehealth session.
- Recognize when a patient isn't a good candidate for telehealth.
- Be willing to have patients attend some in-person appointments – face-to-face visits still add value to the provider-patient relationship.
- Obtain urine drug screen confirmation labs, when appropriate, to verify the patient hasn't been diverting medication.
- Use a paid platform to ensure Health Insurance Portability and Accountability (HIPAA) standards are met.

Details of studies, benefits, and other telehealth information can be found in the link here: Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders (samhsa.gov)

Financial Toxicity: Managing the Effects of Drug Cost for Medicare Advantage Patients

The term "side effect" can bring many things to mind, including gastrointestinal upset, muscle aches, fatigue – the list can go on and on. Practitioners work to achieve positive health outcomes for their patients while minimizing unwanted side effects. Left unresolved, side effects can be a major contributor to patients stopping a medication, resulting in the progression of their chronic condition.

Often, the cost of medications can become an overlooked side effect in medical practice today. This financial toxicity includes both direct cost to the health care system, such as increased ER visits or hospitalization, and indirect costs like decreased productivity or increased need for home health care. When the cost of a medication is too high, patients find themselves choosing between their medicine and other necessary commodities like utility bills and food. They may ration the medication, skip days, delay refilling, or stop taking the medication altogether resulting in an unstable, worsening condition.

This is the first of a four-part series on understanding medication cost and ways to help your patients manage.

Part One: The Medicare Coverage Gap

The Correlation Between Prescribed Meds, The Coverage Gap and Adherence

What is the donut hole?

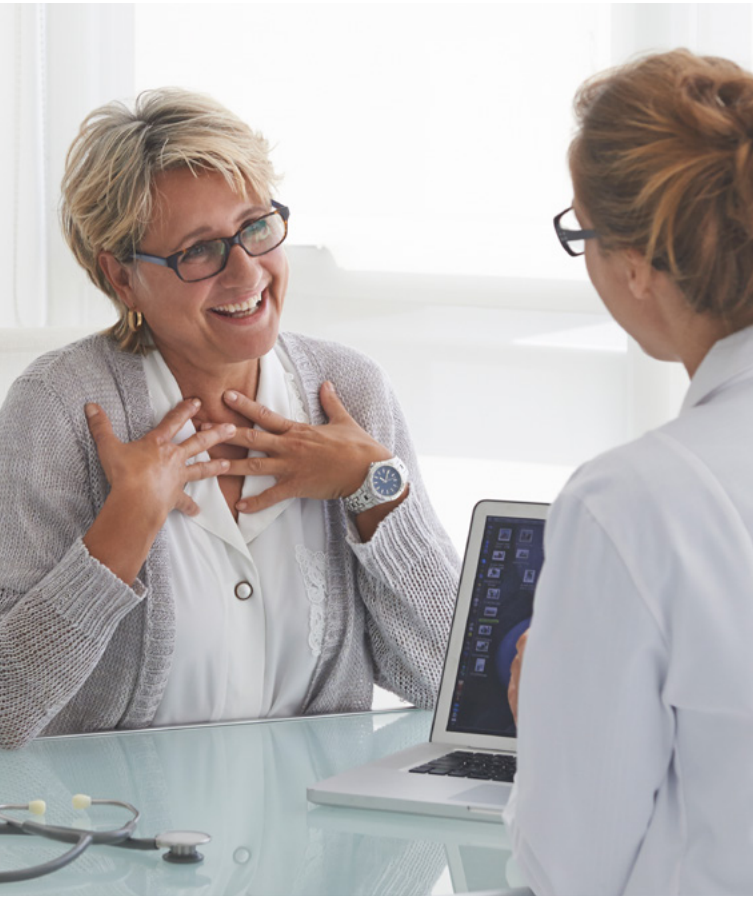
Since Medicare Part D took effect in 2006, the donut hole, more formally called the coverage gap, has been one of the program's most unpopular features. Originally, when Medicare beneficiaries reached the donut hole, they were required to pay 100% of their medication costs. That sharp drop-off in coverage inspired the "donut hole" nickname. In 2011, the Affordable Care Act began closing the donut hole, shrinking it little by little each year. The donut hole closed for all drugs in 2020. However, it still exists because Medicare beneficiaries are responsible for **25% of the cost** of a medication while in this phase of their drug coverage.

How do patients get into the donut hole?

Medicare Part D has four stages: annual deductible, initial coverage, coverage gap and catastrophic coverage. The annual deductible is a limit set by CMS that can be waived by health plans to reduce the cost to beneficiaries. The BlueCross Medicare Advantage plans cover the cost of this deductible for each beneficiary and the member goes directly into the initial coverage stage.

During the initial coverage period, the patient and the drug plan share the cost of medications. Here's how it works:

- The patient pays the co-pay or co-insurance determined by the health plan's drug list and tier level assigned to the drug.
- The health plan pays the remaining cost of the drug.
- The total cost paid by both the patient **AND** the plan count towards moving the patient closer to the donut hole.
- The initial coverage stage ends when the amount spent by the plan and patient **combined** equals the initial coverage limit set by Medicare for that year. For 2022, that limit is $4,430. The patient then enters the coverage gap.



In the Gap

Not every patient will hit the coverage gap, but if they do, they will go from paying their copay to paying 25% of the cost of their medication – which can be a financial burden to some.

Here's an Example:

A BlueCross member in the Ruby plan has a prescription for Trulicity®. The cost is $500. The patient's copay is $28. But, in the coverage gap, the patient now must pay $125. And that may not be their only medication.

During this time, it's not uncommon for patients to ration their medication, skipping days or even stopping the medication altogether due to the financial burden.

How do patients get out of the gap?

Patients exit the coverage gap and enter catastrophic coverage when their out-of-pocket (also known as TrOOP) costs reach $7,050 for 2022. The patient's yearly deductible, coinsurance/copayments, 25% coverage-gap cost share and the brand name manufacturer discount during the coverage gap all apply to TrOOP. The cost share paid by the plan doesn't count toward the TrOOP.

The Bipartisan Budget Act of 2018 increased the manufacturer discount in the coverage gap from **50% in 2018 to 70% in 2019 and beyond**. So, for brand name drugs, 95% (25% patient cost plus 70% manufacturer discount) of the retail drug cost goes toward meeting the patients' out-of-pocket maximum, or coverage gap exit point. The insurance plan pays the remaining 5% of brand name medications, and this amount doesn't apply toward the out-of-pocket cost. For generic medications, the patient's cost of 25% will apply toward their out-of-pocket maximum, but the 75% paid by the plan won't.

How Prescribing Affects the Gap

Prescribing brand name medications will put a patient in the coverage gap much sooner. According to AARP®, the average cost of a brand name prescription medication in 2020 was $550. Based on this number, a patient would enter the coverage gap after eight total fills. If a patient is on multiple brand name medications, they could enter the coverage gap very early in the year.

In comparison, 92% of generic prescriptions are filled at $20 or less. That's 221 fills! Prescribing generic drugs can lower the cost during all stages of Medicare drug coverage and delays or avoids progression into the coverage gap, as well as unintended consequences of financial side effects.

Our Drug List Options

We have two drug list options to help members during the coverage gap.

- Tier 1 preferred generic drugs are covered with a Tier 1 copay even during the coverage gap. This includes generic drugs used to treat diabetes, hypertension, and cholesterol.
- Tier 3 select insulins are covered through the donut hole for PPO members.

Who Pays What Under Part D in 2022

Beneficiary **Plan** **Drug Manufacturers** **Government**

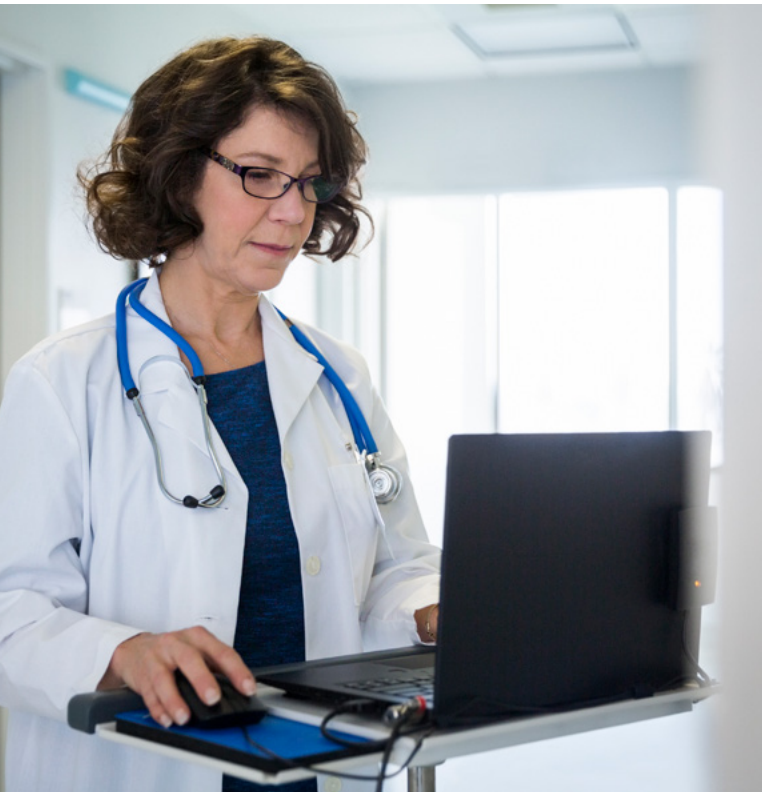
Deductible	**Up to $480**
Initial Coverage (Up to $4,430 spent in total)	**Drug Costs** **25%** **75%**
Former Coverage Gap ("Donut Hole") (Up to $5,582.50 spent during this period)	**Generics** **25%** **75%** **Brand-Name Drugs** **25%** **5%** **70%**
Catastrophic Benefit Period (Beneficiary's total out-of-pocket costs hit $7,050 for year)	**Co-Insurance** **5%** **15%** **80%**

Quality Care Rewards (QCR) Application Update

2022 Provider Assessment Form (PAF) Program Update

Medicare Advantage made changes to the PAF program, effective Jan. 1, 2022. For the 2022 program, there are two options for PAF submission:

- **Electronic PAF:** A new, brief, hierarchical chronic condition (HCC)-focused PAF is in the QCR application in Availity®. You can complete it in the QCR application, export it for completion and upload it to the QCR, or fax it.
- **Non-Standard PAF:** Providers/groups that had an approved non-standard PAF with us in 2021 may continue to submit these assessments for 2022 either by uploading it into the QCR or by fax.
- Note that the previous standard PAF form has been retired and won't be accepted for 2022 dates of service.



Providers will submit the **appropriate CPT®** code once per calendar year when the PAF is complete and submitted in addition to the appropriate visit Evaluation and Management (E/M) code – as a face-to-face visit is still required for PAF documentation. No modifier is needed.

- **Electronic PAF: CPT® code 96161 (new code as of Jan. 1, 2022)**
- **Approved Non-Standard PAF: CPT® code 96160**

How This Benefits You

Our updated PAF is much shorter in length and focuses on addressing and substantiating your patient's conditions. This means no preventive services or extra assessments will be necessary. You'll now see pre-populated information that we already have, including conditions diagnosed and medications prescribed by other providers*. This allows you to remove any diagnosis that's not applicable to your patient for the current year by marking them as inactive or resolved.

* Sensitive medications and conditions such as HIV and behavioral health won't be displayed in the pre-populated fields. Providers will need to re-document these conditions each year.

  Please contact your Medicare Advantage Provider Quality Outreach Consultant for more information about these PAF program updates.

To purchase copies of this publication, including the full measures and specifications, contact NCQA Customer Support at 888-275-7585 or visit **www.ncqa.org/publications**.

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