YOUR GUIDE TO PROGRAMS AND REWARDS

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Understanding and Addressing Substance Use in Tennessee

In 2019, the Centers for Disease Control and Prevention reported that nearly 71,000 people died from drug overdoses, making it a leading cause of injury-related death in the United States. Of those deaths, more than 70% involved a prescription or illicit opioid. These national trends are similar to what we're experiencing in our state.

The Tennessee Department of Health reported in 2020 that rates of drug overdose mortality and morbidity are increasing, and **Tennessee's Annual Overdose Report in 2021** showed that opioid overdose deaths continue to increase. More than 2,000 Tennesseans died from drug overdoses in 2019. While 2020 data is preliminary, the trend of increasing overdose rates through 2019 – combined with the exacerbating effects of the COVID-19 pandemic – have created what current data suggest will be the state's deadliest year for overdose.

Screening for Substance Use Disorder

The goal of substance use disorder (SUD) screening is to identify individuals who have or are at risk for developing drug-related problems. Within that group, it's important to determine which patients need further assessment to diagnose SUD and develop a treatment plan.

For primary care settings, the Substance Abuse and Mental Health Services Administration recommends screening, brief intervention and referral to treatment (SBIRT). Using this model:

- Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment.
- Brief intervention focuses on increasing insight and awareness of substance use and motivating behavioral change.
- Referral to treatment provides those identified as needing more extensive treatment with access to specialty care. The BlueCare℠ Tennessee BESMART network currently has more than 330 prescribers representing 51,370 treatment slots. This network has served close to 7,000 distinct BlueCare members since Aug. 2018.

Best Practices for Primary Care Providers

We encourage providers to review evidence-based SUD resources, such as:

- Education on SBIRT
- Behavioral health screening tools and codes
- The Behavioral Health in Pediatrics (BeHiP) program, which promotes assessment and screening of SUD issues in pediatric primary care practices.

Additionally, we recommend providers check the Controlled Substance Monitoring Database (CSMD) before prescribing a controlled substance. The CSMD equips health care providers with accurate, timely information by providing a historical record of patients' controlled substance use.

By working together to raise awareness of SUD and screening, we can connect patients to the treatment they need and begin to curb the rising rates of substance use in Tennessee.

Jeanne James, MD, FAAP

Vice President and Chief Medical Officer

BlueCare Tennessee

Cumberland Heights Foundation

A Statewide Leader in Care for Substance Use Disorders

Cumberland Heights Foundation has cared for patients in Middle Tennessee with substance use disorders since 1966, a time when high-quality treatment was difficult to find and addiction was considered a moral weakness. As the understanding of addiction has evolved, Cumberland Heights Foundation has remained at the forefront of treatment, particularly in research and data-driven care. The Nashville-based non-profit organization has a 177-acre main campus and 15 satellite clinics throughout the state. It provides a full continuum of inpatient and outpatient care, including peer support and telehealth services.

The team's emphasis on research, evidence-based care and long-term support for patients has positioned Cumberland Heights Foundation as a leader not just in the state, but also in the nation. In 2022, the Research Institute at Cumberland Heights Foundation received the Dr. James West Quality Improvement Award from the National Association of Addiction Treatment Providers. The practice is also accredited by the American Society of Addiction Medicine and is the only BlueCross Substance Use Disorder Center of Distinction in Tennessee.

An All-Encompassing Approach to Addressing Substance Use Disorders

Cumberland Heights Foundation cares for adult and adolescent patients and offers all levels of care – from detoxification and residential treatment to partial hospitalization, intensive outpatient programs and extensive long-term follow up.

"Essentially, any patient in the state who needs the highest level of care, which would be medical detox, can continue treatment in their communities through our 15 physical satellite locations," said Jay Crosson, Chief Executive Officer at the Cumberland Heights Foundation. "We're also using telehealth to treat people in rural areas so they don't have to travel to a clinic every week."

To help ensure patients have adequate support after they complete treatment, Cumberland Heights Foundation hired several peer recovery specialists in 2016. These specialists meet with patients while they're in the residential treatment facility and follow them for one year. There's no cost for these services, which give patients an additional resource if they're struggling.

"Our broad continuum of services across the state allows us to walk with our patients clinically for longer periods of time," Crosson said. "If patients are unable to abstain from their drug of choice, we can bump them up to a higher level of care and revent or address a relapse."

Promoting Data-Driven Treatment

One challenge in addiction medicine Crosson noted is using data to demonstrate the benefits of treatment.

"I believe that substance use disorder facilities, and behavioral health in general, have done a poor job of communicating the effectiveness of what we do for our patients and families," Crosson said. "Part of the reason is it's difficult to measure."

"We need to invest in our ability to tell that story in data so we can communicate more effectively and develop better, more effective treatments," added Nicholas Hayes, PhD, Chief Science Officer at the Cumberland Heights Foundation.

Dr. Hayes joined the team in 2018 and has led the development of an onsite Research Institute. Through the Research Institute, seven standard assessments are collected weekly from patients receiving inpatient and outpatient care. The team looks at multiple data points, including the prevalence of anxiety and depression, post-discharge outcomes, and a reduction in craving symptoms, and adjusts treatment accordingly. In 2021, the Research Institute was able to demonstrate a 68% reduction in depression symptoms, a 63% reduction in anxiety symptoms and a 74% reduction in cravings.

"Our clinicians can look at the assessments and review them with patients while they're in treatment," Crosson said. "They can demonstrate how the patient is getting better or note any spikes in symptoms. If a patient is having higher levels of anxiety, we can address the reason. Having those informed conversations with patients really improves treatment for each individual."

Moving forward, Hayes hopes to share data amongst multiple providers, including those across our state. Currently, Cumberland Heights Foundation is working with six organizations throughout the nation to develop a centralized data repository.

"We want to use this data in the aggregate every year to look at, for example, demographics and if patients are experiencing better outcomes on certain medications," Dr. Hayes said. "What's exciting is there seems to be a lot of traction now for data-sharing. We believe the best days are ahead."

Partnering with Community Providers

Identifying substance use disorders and connecting patients to treatment can be a challenge. To help ensure patients with a substance use disorder receive the care they need, Dr. Hayes recommends primary care practices use a screening tool to assess patients during visits.

"Generally, you want to know the nature, length and intensity of someone's substance use," Dr. Hayes said. "Adopting an assessment tool is a great first step. The next step would be having a network of supportive providers who can help triage patients who might benefit medically and psychologically from treatment. We're happy to work with providers and have those conversations."

Cumberland Heights Foundation offers free assessments, including mobile assessments in Middle Tennessee.

"If in doubt, they can refer to us," Crosson said. "There's so much stigma associated with this disease. Patients are less likely to volunteer that they're struggling, and some clinicians may be hesitant to ask those questions. We need to be brave enough to treat the whole patient, regardless of their illness."

Measuring Outcomes in Your Practice

You don't need to have an onsite research institute to maximize the use of data in your practice. Identifying what types of assessments work best and using evidence-based tools are great places to start, according to Jay Crosson, Chief Executive Officer at Cumberland Heights Foundation.

"We've been using patient satisfaction surveys since the 1970s," Crosson said. "That's a form of information, but it doesn't have the rigor of the research we're doing now. I would also recommend practices use validated, evidence-based resources. We used to create our own suicide risk assessment, but now, we use a standardized tool. That's been a movement for us, and that's a place anyone can start."

Clinical Focus

Medication Compliance for Patients Diagnosed with Schizophrenia

For patients diagnosed with schizophrenia, medication adherence is often underestimated. One third of those diagnosed with schizophrenia don't take their medication as prescribed. Non-compliance results in an increased risk of relapse and self-harm, and can be intentional, non-intentional or both.

The reasons patients don't take these medications can include:

- Dissatisfaction with the treatment response
- Their attitude toward medication
- The cost
- Poor insight
- A history of non-adherence
- Delusions

Side effects are another driver for non-compliance and should be routinely evaluated and addressed. Those at greatest risk tend to be younger, non-white, have a history of co-morbid substance use and have a history of psychiatric hospitalization.

Because there are differing reasons for non-compliance, interventions should be customized to the needs of the patient and can include psychoeducation, psychosocial interventions, long-acting medications, electronic reminders, service-based interventions and financial incentives. A combination of these options may be best.

There are several things to consider while working to improve patient compliance:

- Consider shared decision-making when developing a plan
- Work to simplify the regimen
- Ensure side effects are managed and that treatment is effective

Compliance results in reduced rates of re-hospitalization, depression, social isolation, substance misuse, stigma and long-term chronic illness, which improves the quality of life for those diagnosed with schizophrenia.

New This Year: Transitions of Care Measure

The Centers for Medicare and Medicaid Services (CMS) retired the stand-alone Medication Reconciliation Post-Discharge (MRP) measure at the end of 2021 and replaced it with the Transitions of Care (TRC) measure for 2022.

The single-weighted TRC measure incorporates MRP with three additional components:

- **Notification of inpatient admission** – Documentation in the outpatient medical record must include evidence of receipt of a notification of inpatient admission (with evidence of the date received) on the day of admission, or through the second day after admission (three total days).
- **Receipt of discharge information** –Documentation must include evidence of receipt of discharge information (with evidence of the date it was received) on the day of discharge, or through the second day after discharge (three total days). Discharge information may be included in, but not limited to, a discharge summary or summary of care record, or be located in structured fields in an electronic health record (EHR).
- **Patient engagement after inpatient discharge** – Documentation of patient engagement (e.g., office visits, visits to the home, or telehealth) must be provided within 30 days after discharge. Don't include patient engagement that occurs on the date of discharge.

The TRC measure assesses the percentage of discharges (acute and/or non-acute) for members, 18 years and older, who had each of the four reported components between Jan. 1 and Dec. 1 of the measurement year. Each component receives a rate, and the rate for the measure is calculated using the average of the rates of each of the four components. Members may be in the measure more than once if there are multiple discharges during the measurement year.

The TRC measure includes:

- All discharges on or between Jan. 1 and Dec. 1 of the measurement year
- The last discharge for direct transfers or readmissions within 30 days of discharge

Members who receive hospice care anytime during the measurement year are excluded from this measure.

Information on appropriate medical record documentation and administrative codes is included in your **2022 Medicare Advantage Quality Program Information Guide** and the **TRC booklet** available on our Medicare Advantage Quality Initiatives page on the **provider.bcbst.com** site.

Appropriate Coding for Imaging Studies for Low Back Pain

The HEDIS® measure for Use of Imaging Studies for Low Back Pain (LBP) indicates patients with a primary diagnosis of uncomplicated low back pain should wait 28 days or more after a primary diagnosis before they undergo an imaging study (plain X-ray, MRI or CT scan).

Here are some coding tips to help avoid an open gap in care:

- When low back pain is the secondary diagnosis on the claim and the patient undergoes an imaging study, the gap won't open.
- Include documentation and coding, along with the diagnosis of LBP, on the claim for "red-flag" conditions (exclusions) where an imaging study should be ordered. This will prevent an open gap that can't be closed. There's a six-month review period for any primary diagnosis of LBP during that time. Keep in mind, if this gap opens, it can't be closed.

Encourage patients to try conservative treatments, such as ice, heat, over-the-counter pain relief, stretching or back straightening exercises and safe back habits.

Exclusions and "red flag" diagnoses for the measure include:

- Cancer
- Neurological impairment
- Recent trauma
- Intravenous (IV) drug abuse
- Lumbar surgery
- Prolonged use of corticosteroids
- Kidney transplant
- Major organ transplant
- Spinal infection
- Fragility fracture
- Human immunodeficiency virus (HIV)
- Osteoporosis medication therapy
- Spondylopathy
- Hospice

For more information and guidance on this measure, refer to our **Low Back Pain Toolkit** and **Coding Guide**.

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

Resources for Child and Adolescent Well Visits

Contacting patients who are past due for an Early and Periodic Screening, Diagnostic and Treatment (EPSDT) visit is the first step towards ensuring children and teens get the care they need. Consider these best practices to maximize your outreach efforts.

Tailor Your Message

Your outreach will look different if you're sharing patient-specific information about children who are past due for care or if you're simply reminding families about an upcoming appointment. Similarly, you'd use different messaging if you're calling patients on the phone, sending a text message, or sharing details on social media about an upcoming event or a change in office hours.

Use Our Quality Care Rewards Application in Availity® to Target Your Outreach

To find out if patients assigned to you are past due for care, select the BlueCare EPSDT Program from the All Programs drop-down menu within the Quality Care Rewards application. There, you'll be able to export gap lists with compliant and non-compliant member details and review payment opportunity reports. If you have questions or need help using the application, please contact your **eBusiness Regional Marketing Consultant** or call **(423) 535-5717, option 2**, to speak with our eBusiness Service Center.

Work with Our BlueCare Tennessee Community Care Partners

We're here to help and have a dedicated team that can work closely with your office and local agencies to coordinate community-based events. We can help identify patients to invite, find the best event location, coordinate times and more. If you'd like to learn more about how we can work with your practice, please call **1-800-771-0217**.

For more best practices and to review call script, text message and social media outreach examples, please refer to pages 17-19 of our **EPSDT Provider Booklet**.

10 Tips to Promote Preventive Care*

Summer is a great time to promote checkups and keep kids on track with preventive services. As you schedule your patients' wellness exams, consider these 10 tips to help you meet the requirements of the child and adolescent wellness HEDIS measures.

* This information applies to patients with BlueCare, TennCareSelect and BlueCross Commercial coverage unless otherwise noted.

1. The age of your patient determines how often they need a well-check visit.
    a. Children need at least six well visits with a primary care provider (PCP) before turning 15 months old.
    b. Children between ages 15 and 30 months need at least two visits with their PCP.
    c. Children and teens between 3 and 21 years need at least one well visit each year with either their PCP or OB/GYN.
2. To close a HEDIS gap in care, checkups **shouldn't** include services for an acute or chronic condition.
    a. **Note:** If patients with BlueCare Tennessee coverage are past due for an EPSDT visit, providers **can** complete an EPSDT exam during visits for other types of services and receive reimbursement for both types of care. For more information about performing and billing EPSDT exams, please see our **EPSDT Provider Booklet**.
3. Services performed during an inpatient or emergency room visit **don't** count as wellness visits.
4. Samples of well-care visit codes include: 99381-99385, 99391- 99395, 99461, G0438, G0439, S0610, S0612, S0613, Z00.00, Z00.01, Z00.129, Z01.411, Z01.419 and Z02.5.
5. When documenting patient data to meet the well-care body mass index (WCC_BMI) requirements, please list all components needed:
    a. Height
    b. Weight
    c. BMI percentile (The BMI percentile can be plotted on a BMI chart or documented in the record as a percentile.)
6. You can easily find a list of your patients that need a well visit this year in the Quality Care Rewards application.
7. Well-child forms are available on the **Tennessee Chapter of the American Academy of Pediatrics (TNAAP) website**. If properly and fully completed, these forms address all components of the well-child measures, so we recommend using them.
    a. We're working with TNAAP to host a training for providers caring for patients with BlueCare Tennessee coverage. Mark your calendars for a virtual EPSDT workshop on Aug. 11 from 12:30 to 2:30 p.m. CT. We'll share more details closer to the event.
8. Well-care visits can now be done through synchronous (real-time audio and video) telehealth visits.
    a. When providing telehealth services using real-time audio and video telecommunications systems, you can code place of service (POS) 02 or 10, or use your normal POS code with a 95 modifier.
9. Coding is key. The best way to show that gaps for well visits have been closed is through correct claims submissions.
10. We have several resources to help you, including our Quality Measures Guides, telehealth guides and more. To view our Quality Measures Guides for all lines of business, please visit **provider.bcbst.com/working-with-us/quality-initiatives**. Telehealth guides for all lines of business are available in the **BlueCare Tennessee Providers** and **All Other Providers FAQ** documents on **bcbstupdates.com**.
    a. If you have questions, need help using the application or would like to schedule training on using Availity for your practice, please contact your eBusiness Regional Marketing Consultant or call **(423) 535-5717, option 2.**

How to Help Your Patients with COPD Manage or Reduce Exacerbations

According to the American Lung Association, chronic obstructive pulmonary disease (COPD) is the third leading cause of death in the United States, and women are more likely than men to die from the disorder. Early signs of COPD are rarely reported and are often overlooked as normal signs of aging.

The Pharmacotherapy Management of COPD Exacerbations (PCE) HEDIS measure states that patients aged 40 and up that are discharged from an acute inpatient hospital stay or ER visit should have the following medications prescribed and filled:

- Corticosteroids within 14 days of discharge

AND

- Bronchodilators within 30 days of discharge

Strategies to Help You Improve Inpatient Adherence and Close Gaps in Care

- Assist patients in preparing a COPD Management Plan to reduce exacerbations.
- Review early warning signs of an exacerbation with your patients.
- Educate patients on the importance of staying active and how to pace themselves.
- Discuss both maintenance and rescue bronchodilator adherence with patients.
- Emphasize the importance of following up with the patient's PCP after any visit to the hospital, regardless of admission.
- Educate patients on the importance of taking all medication as prescribed after discharge.
- Evaluate possible triggers with patients, including air quality, pollen counts and smoke.
- Follow the CDC's recommendations for vaccinations, including pneumonia and annual flu vaccines.
- Discuss plans of care with patients, including quality-of-life and end-of-life care planning when appropriate.

Treating Patients with Asthma

Use these strategies to improve patients' medication compliance

According to the CDC, approximately 25 million people in the United States (8% of adults and 7% of children) have asthma. It's the leading chronic disease in children.

Medication adherence is key when helping patients control their asthma symptoms. The HEDIS Asthma Medication Ratio (AMR) measure focuses on the percentage of patients, 5-64 years old, who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater (measured as medication units) during the measurement year.

Help Improve Patient Compliance and Close Gaps in Care

Make sure asthma diagnoses are coded correctly. Avoid coding asthma if the diagnosis is for asthma like symptoms (e.g., wheezing during a viral upper respiratory infection or acute bronchitis).

It's also important to code for any diagnoses on the exclusion list:

- Patients in hospice
- COPD
- Obstructive chronic bronchitis
- Emphysema
- Cystic fibrosis
- Acute respiratory failure
- Chronic respiratory conditions

Educate your patients on the types of asthma medications. Patients don't always understand the difference between long-acting controller and rescue medications. The ratio for the AMR measure is calculated by totaling the units of controller medications and dividing it by the total of all asthma medication for the year.

Here's how it's calculated:

- Units of controller medications/units of total asthma medications units.
- Count each individual medication, defined as an amount lasting 30 days or less, as one medication unit. One medication unit equals one inhaler canister, one injection, one infusion, or a 30-day or less supply of an oral medication.

We have several resources to help you, including HEDIS measures guides, telehealth guides, member brochures and more. You can access these at **https://provider.bcbst.com/working-with-us/quality-initiatives/**

Managing the Effects of Drug Costs for Medicare Advantage Patients

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

Part Two: Real-Time Benefit Checks Decrease Prescription Abandonment, Increase Medication Adherence Rates

Many patients don't know how much their prescription medications will cost until they pick them up at the pharmacy. When patients on a fixed budget or those with major health problems are faced with an unexpected high cost of medications, they often make decisions that could ultimately impact their health. They may decide not to fill the prescription, skip doses, take expired medication, cut pills in half or even share a prescription.

CMS issued a final rule on May 16, 2019, that modernized and improved the Medicare Advantage and Part D programs to help make patients aware of the cost of prescription drugs. The rule required each Part D plan to adopt one or more Real-Time Benefit Tools (RTBT) capable of integrating with at least one prescriber's ePrescribing system or EHR, no later than Jan. 1, 2021.

What are Real-Time Benefit Checks?

Real-time benefits (RTB) checks provide a way for prescribers to identify exact patient out-of-pocket costs at the point of prescribing. Not only does this increase price transparency, but it also allows providers to make helpful decisions at the point of prescribing. Providers who use RTB information can:

- Determine if the medication prescribed is covered and learn the patient's out-of-pocket cost
- See and select clinically appropriate lower-cost brand or generic alternatives
- Know which therapy options require prior authorization (PA) or have other restrictions
- Process a PA in real-time from the EHR (if the EHR also supports ePA)

How Does RTB Work Within e-Prescribing?

RTB checks are set up within the electronic prescribing workflow in the EHR. For BlueCross, EHR vendors access RTB information from CVS Caremark® through Surescripts® – which is the national network for electronic prescribing.

Here's the RTB data transaction flow:

- The provider enters the prescription information (e.g., drug, quantity, day supply, pharmacy) into the e-prescribing workflow of the EHR.
- The EHR e-prescribing system triggers a data call to Surescripts.
- Surescripts transmits this data to CVS Caremark.
- CVS Caremark "mock adjudicates" the drug information to show the patient cost and coverage information.
- The information is sent to the EHR through Surescripts.
- The EHR displays this information, within the e-prescribing workflow, with an average response time of three seconds or less.
- The RTB screen will clearly show the patient's out-of-pocket cost, alternative medication options and costs, and member-specific utilization management restrictions for each drug.

Is RTB Information Specific to a Plan Member and Their Drug List Information?

Yes, the information returned is for the specific patient (member). The database displays up to five clinically appropriate, lower-cost brand or generic alternatives with equal or better formulary status on the patient's specific pharmacy benefit design, and the real-time out-of-pocket cost. In addition, it shows information on any restrictions, such as whether or not a PA is required.

How Does This Benefit Patient Care?

RTB checks empower providers and patients to make customized, informed decisions. Providers can communicate costs to patients at the point of care and allow for open dialogue about financial resources and concerns. Therapies can be adjusted or changed during the office visit making treatment easier for the patient.

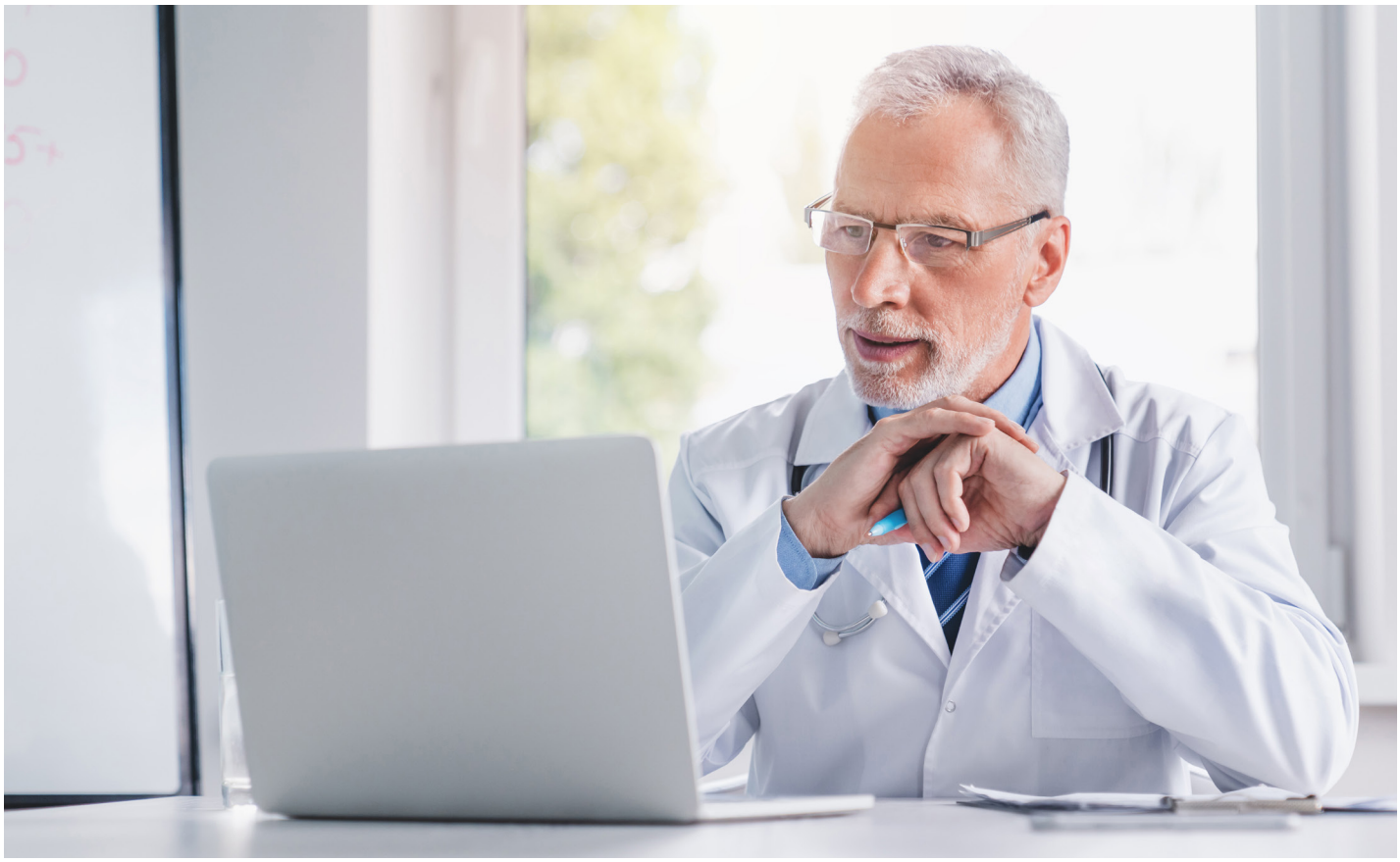
Providers can help reduce prescription abandonment and improve medication adherence rates by informing patients about medication costs at the point of prescribing and determining if the medication is affordable for them.

Quality Care Rewards (QCR) Application Update

QCR Gets New Look with Additional Details

The QCR application is being restructured and will have an updated look. All current functionalities will be available, but now our technical platform will display a tile platform you can use to access the tasks you need more easily.

A user guide and diagrams for functionalities will be available on QCR under Resources a few weeks prior to the release. The QCR home page, accessed through Availity®, will have additional details and the exact release date.



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