of Tennessee | Mission driven FOR 75 Years

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Provider Network Operations

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Provider Enrollment Form

Overview

- Available online for medical, dental and behavioral health practitioners
- Automations, supporting document submissions
- Register with CAQH and Availity® for the best experience
- The strategy behind this new and innovative way of enrolling our valued customers is to ensure the process becomes more of a positive experience
- Support options 

If you have questions, please email ProviderSupport@bcbst.com or call Provider Network Services at 1-800-924-7141 and select either touchtone (Option 1) or voice (say "voice").

bcbst.com/providers  

Provider Enrollment Process

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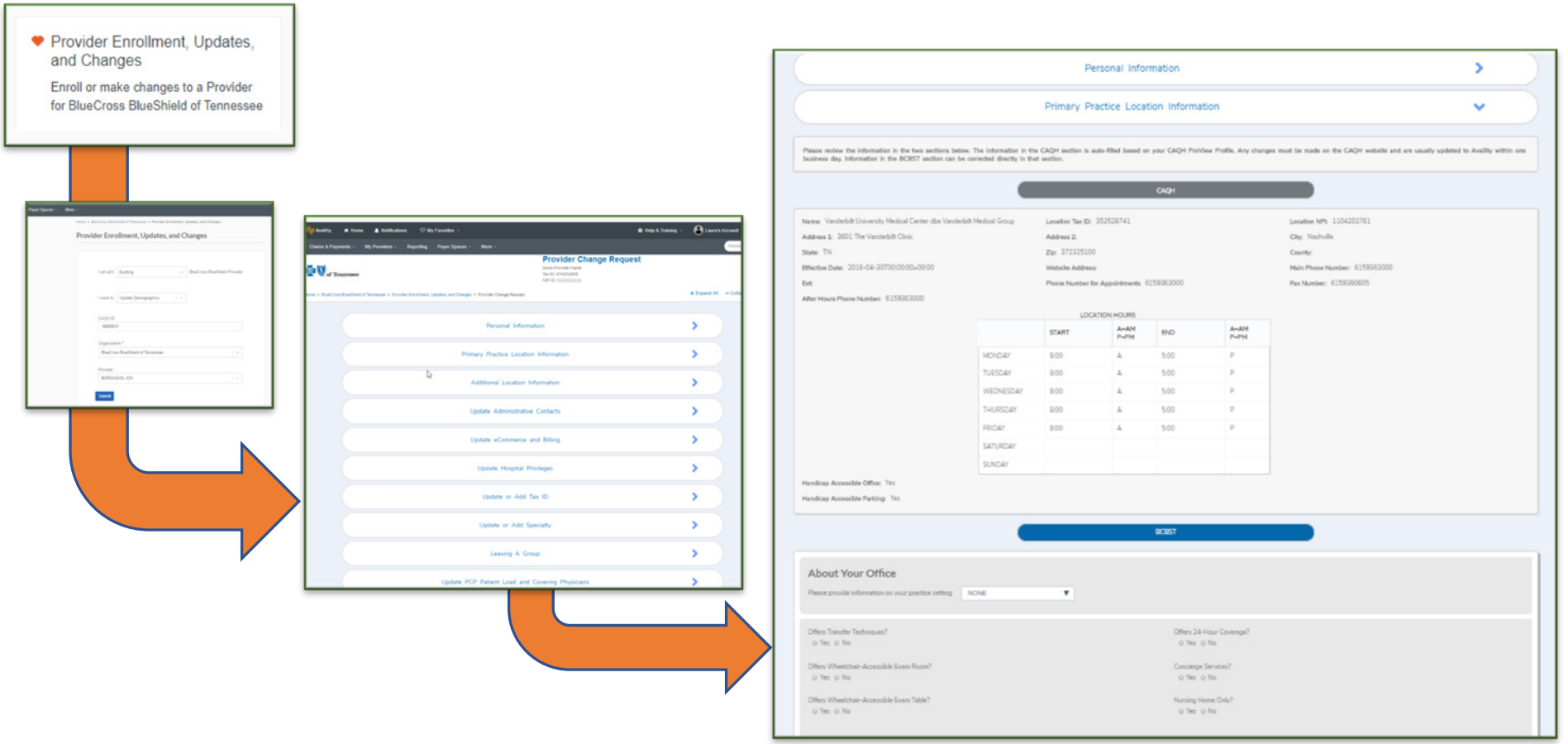
New Digital Change Form

Through Availity

- We have a new way to accept provider demographic changes.
- Most provider demographic information is updated via CAQH ProView and automatically transferred to BlueCross systems.
- BlueCross-specific information not captured through CAQH, such as eCommerce, Patient Acceptance and PCP information, can be updated through the new Change Request form on the BlueCross Payer Space in Availity.

Change Requests

Through Availity



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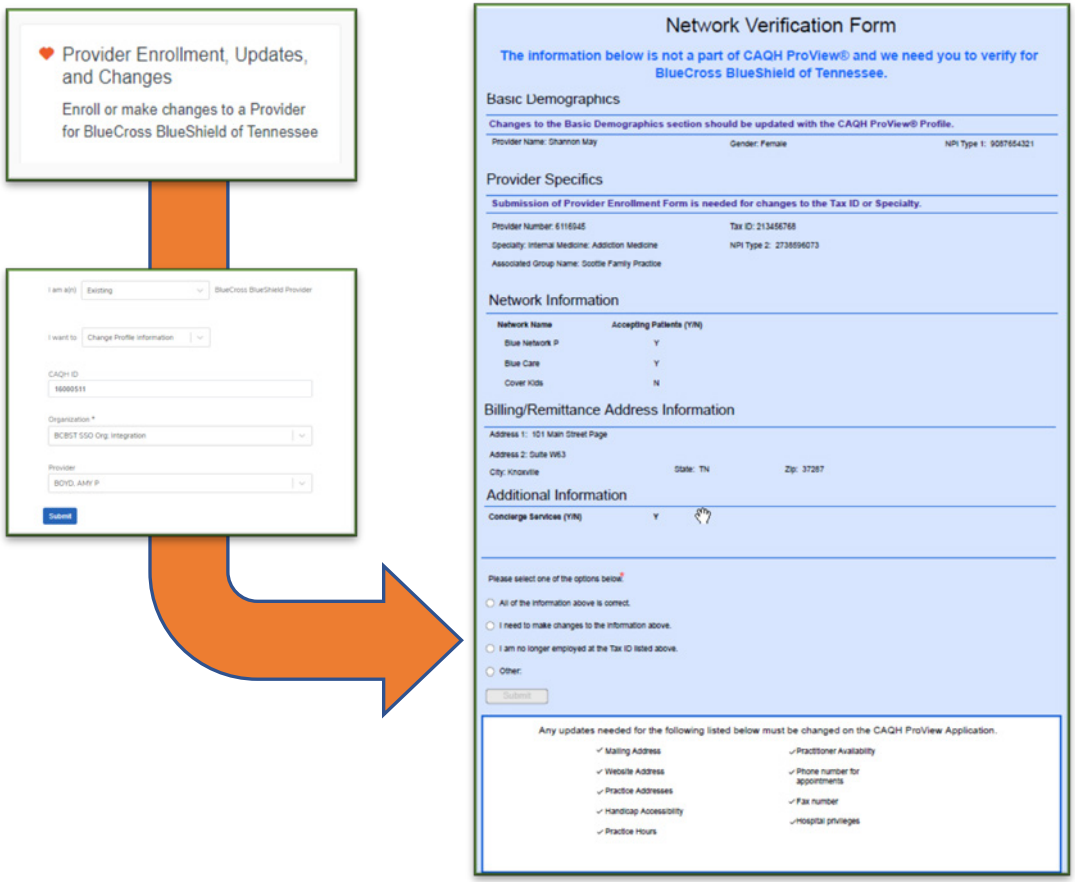
Network Verification Form

Through Availity

- Completion of the Network Verification Form is required on a quarterly basis, per the Centers for Medicare and Medicaid (CMS).
- Provider directory information, such as locations, office hours, practitioner availability and hospital affiliations, is collected and integrated through CAQH.
- BlueCross-specific information not captured by CAQH, such as network verification and patient acceptance, can be updated on a new form in the BlueCross Payer Space in Availity.
- Be sure and attest with CAQH to avoid future data verification mailings.

Network Verification Form

Through Availity



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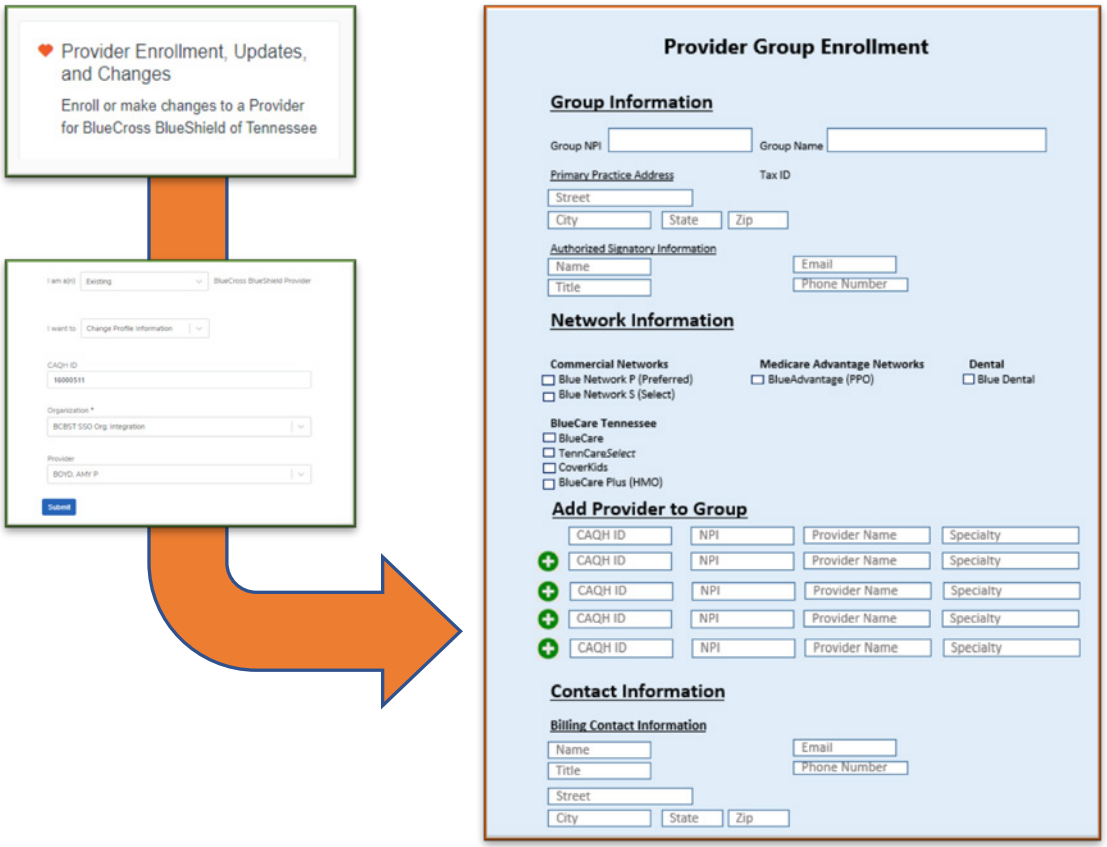
Group Enrollment — Upcoming

Consolidating multiple applications into one

- **Groups can submit one application with up to 15 providers instead of submitting one per provider.**
- Existing groups will gain staff efficiencies as we prepopulate their group data and network affiliations from our internal systems.
- Groups new to BlueCross will be able to automatically populate their provider demographics data with CAQH IDs.
- Our flexible enrollment processes will allow each individual practitioner to move along independently from those that may require additional research or documentation.

Group Enrollment — Upcoming

Consolidating multiple applications into one



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Provider Improvements

Provider experience minded

- Provider data strategy
- Consumer experience and automation
- Network verification

Get more details in **Breakout Session 1** at 12:40 p.m.

Questions?

eBusiness & Availity

Enabling Digital Operations

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Agenda

Key & upcoming features on Availity

Key Features

- Eligibility & Benefits
- Claim Status
- Remittance Viewer
- Payer Spaces
  - Authorization Submission & Review
  - Contact Preferences
  - Fee Schedule Viewer

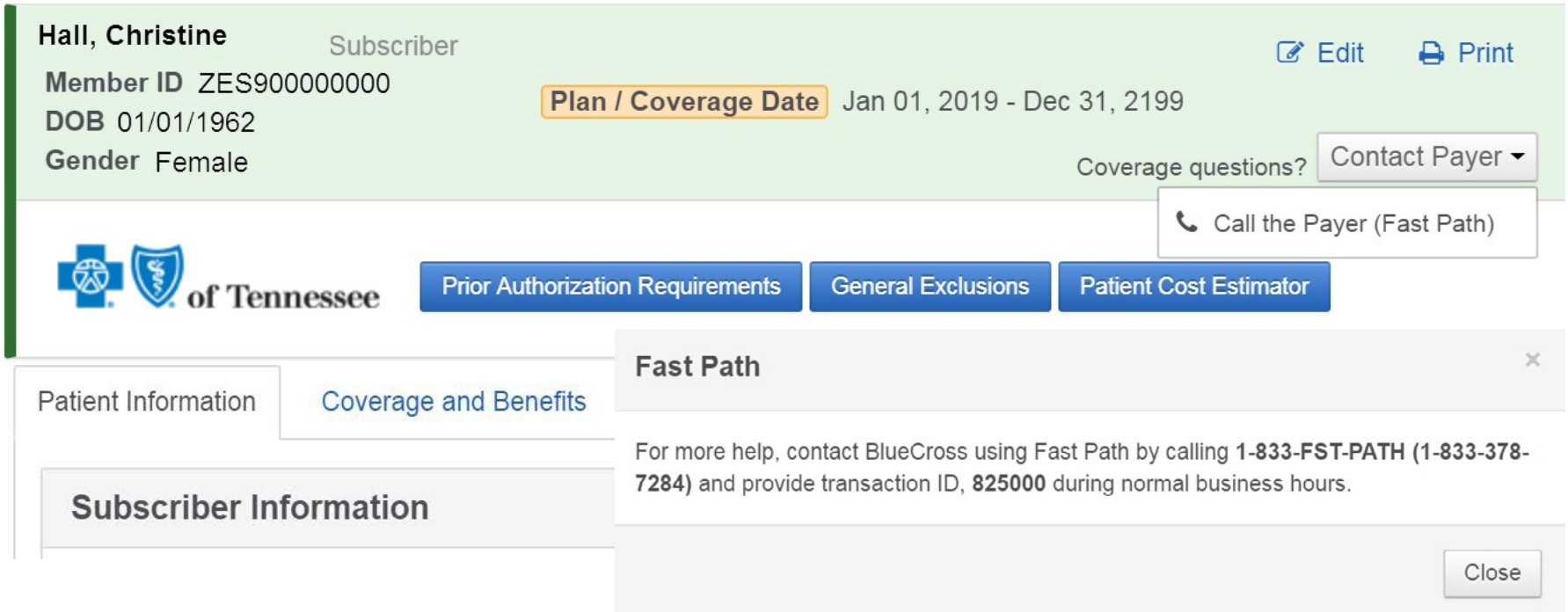
Upcoming Features

- Messaging
- Attachments
- Dental Benefit Upgrade

Eligibility & Benefits

Fast Path, coverage & benefits, prior authorization requirements, exclusions and patient cost estimator

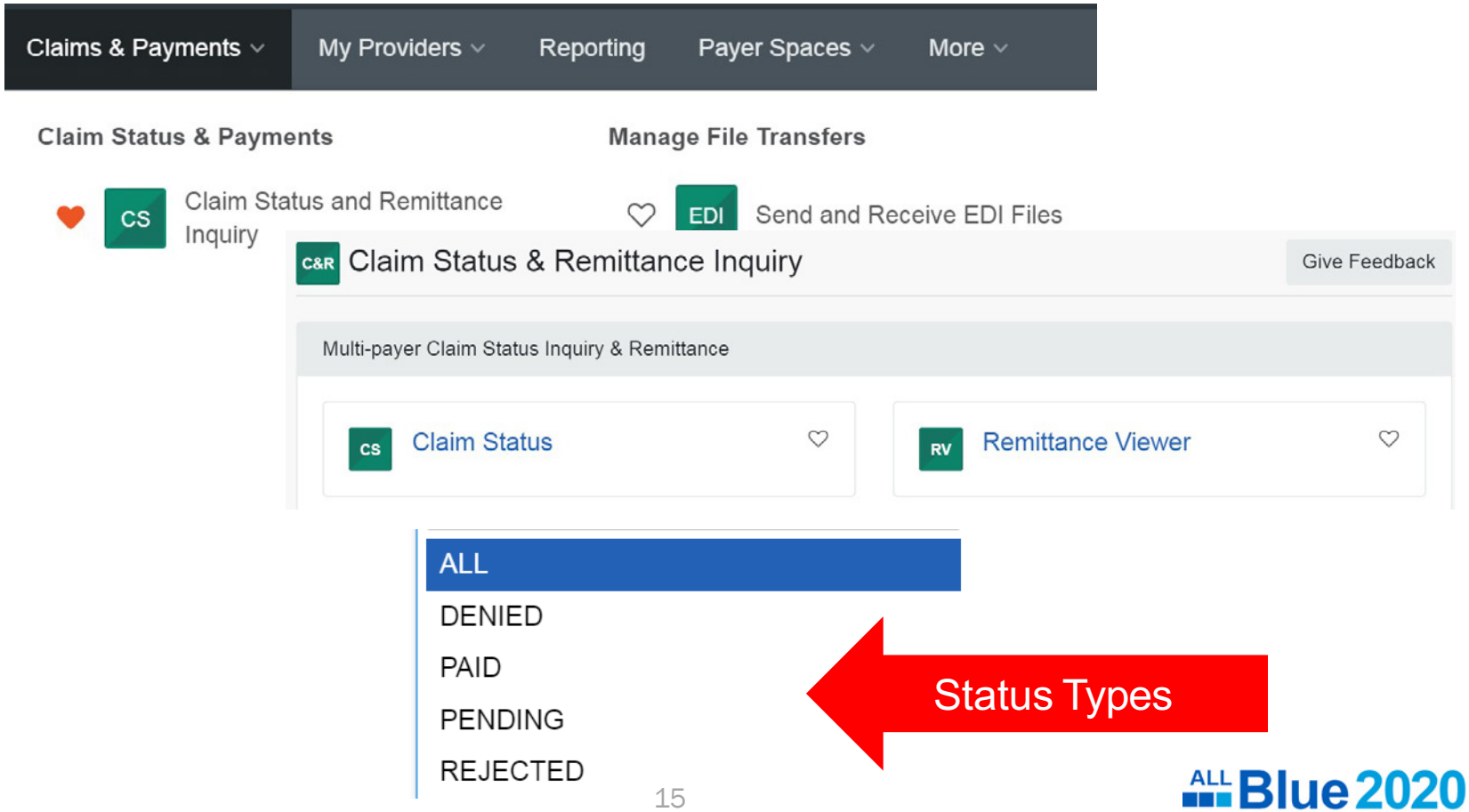
If you make an inquiry in Availity and can't get the information you need, the system will provide you with a Fast Path phone number and a Fast Path ID to contact Provider Service for help.



Claim Status

Review claims submitted to BlueCross

To view Claim Status:



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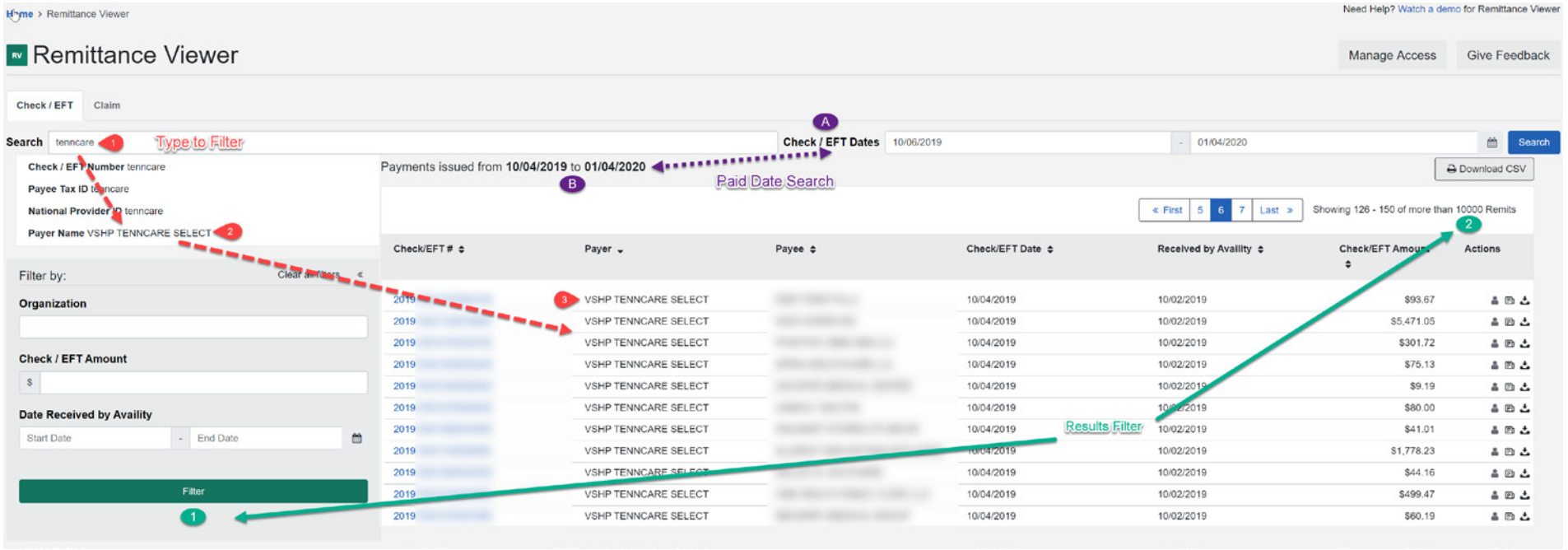
Remittance Viewer

Upgraded for 2020

Availity's new Remittance Viewer features an upgraded interface and includes easy ways to search all your payment data, such as:

- Type to Filter
- Paid Date Search
- Results Filter



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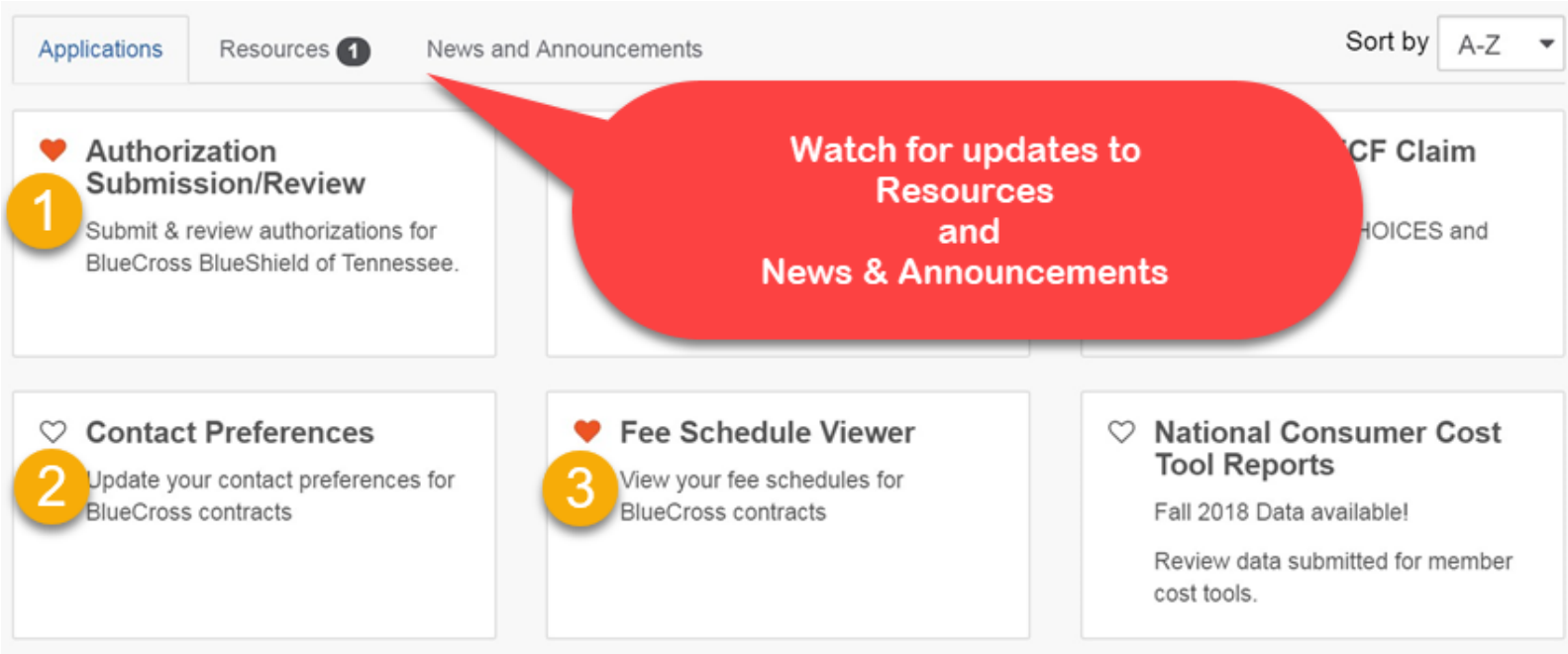
Payer Spaces

Applications, resources & news and announcements

Payer Spaces houses content and applications specific to how BlueCross does business with you. Key workflows include authorizations, contact preference management and fee schedule review.



What's Next?

Availity messaging and medical records

Our goal in eBusiness is to understand provider workflows and develop solutions that:

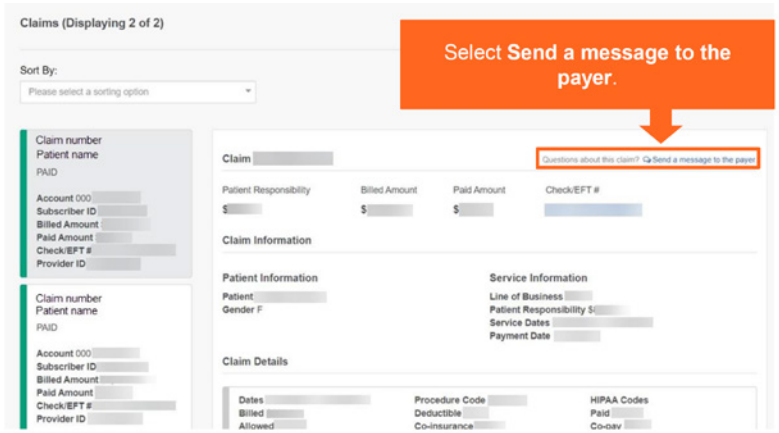
- Reduce overall interaction times
- Provide more flexible engagement channels
- Give you what you need, when you need it, to give you the time to care for our members

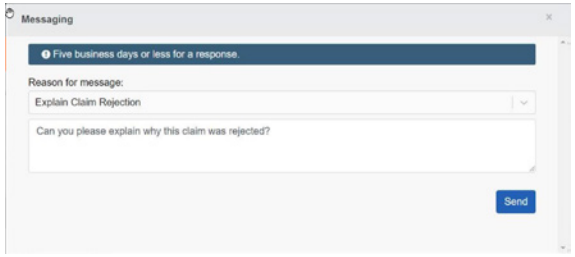
We are excited to share upcoming features with you today and look forward to delivering more value to you in 2020.

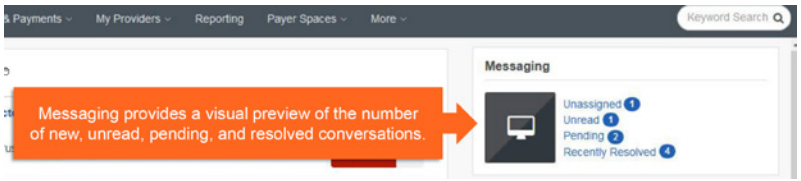
Availity Messaging

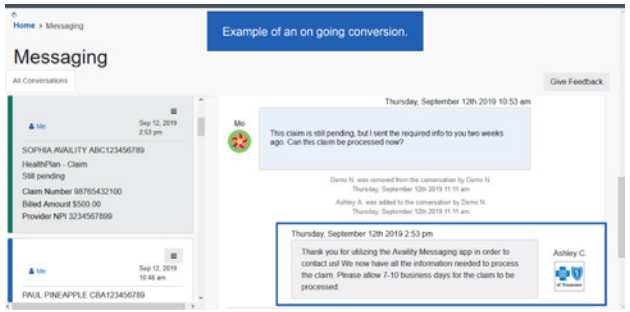
Opening new customer service channels

Messaging is a new capability that will allow providers to send questions about claims from within Claim Status. All conversations can be managed by providers and their administrators; responses will be sent directly from the customer service teams researching your inquiries.





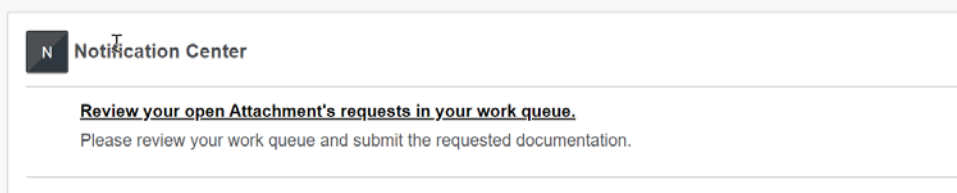


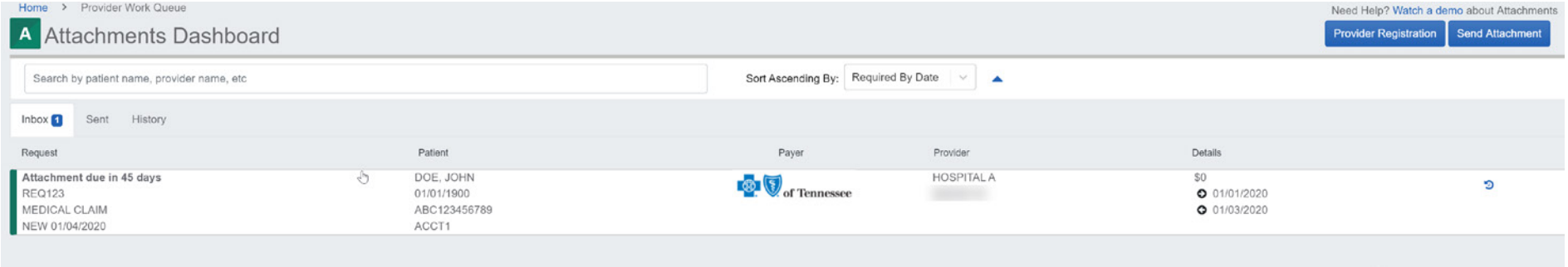


Availity Attachments

Providing quick access to submit records

Availity Attachments will allow providers to receive requests for documents needed to support claims processing and other operational needs. Providers will receive a request along with a timeframe to upload; once submitted status will be updated when BlueCross receives the record successfully. Look for pilot notifications soon.

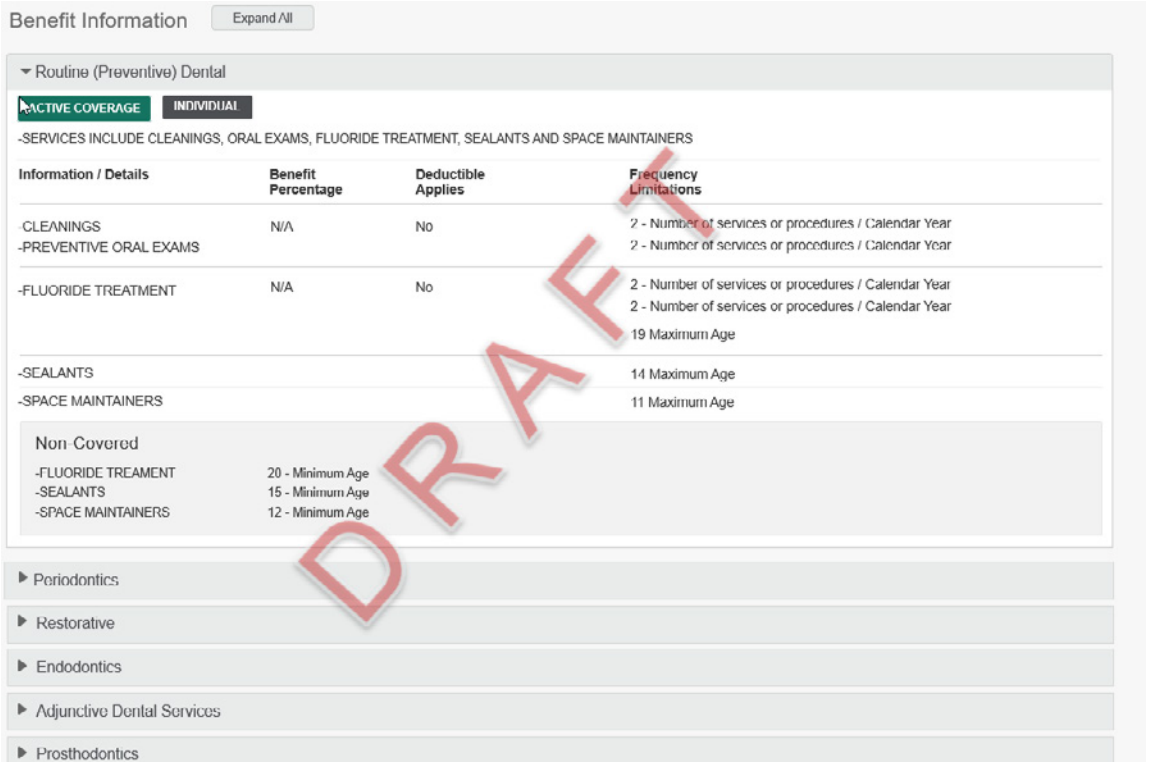




Dental Benefits Upgrade

Providing greater detail for member benefits

BlueCross is working to increase the usability and details available for our Dental members. Look for further announcements during 2020 as we implement changes to these benefits.



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eBusiness Solutions & Availity

We're here to help!

eBusiness Service Center

- **Phone:** (423) 535-5717, option 2
- **Hours:** M–Th, 8 a.m.–6 p.m. and F, 9 a.m.–6 p.m.
- **Email:** ebusiness_service@bcbst.com
- **Chat**: Chat with Payer on BlueCross Payer Space

Availity Portal Support

- **Phone:** 1-800-282-4548
- **Online:** Open a support ticket via your Provider Engagement Portal Account **(Click My Account | Open a Ticket)**

eBusiness Regional Marketing Consultants

- **Faith Daniel, East TN**
  - **Phone:** (423) 535-6796
  - **Email:** Faith_Daniel@bcbst.com
- **Faye Mangold, Middle TN**
  - **Phone:** (423) 535-2750
  - **Email:** Faye_Mangold@bcbst.com
- **Debbie Angner, West TN**
  - **Phone:** (901) 544-2285
  - **Email:** Debbie_Angner@bcbst.com

eBusiness & Availity

Have Questions?

Enterprise Quality

Peace of Mind Through Better Health

ALL Blue 2020

Quality Care

What is it?

The Agency for Healthcare Research and Quality defines Quality Healthcare as:

"Doing the right thing for the right patient, at the right time, in the right way to achieve the best possible results."

Quality Care

Why is this important?

Educating patients to focus on preventive care and chronic condition management empowers them to:

- Stay in control of their health care
- Be up-to-date on recommendations
- Make informed decisions
- Be as healthy as they can be

Patient Health Planners

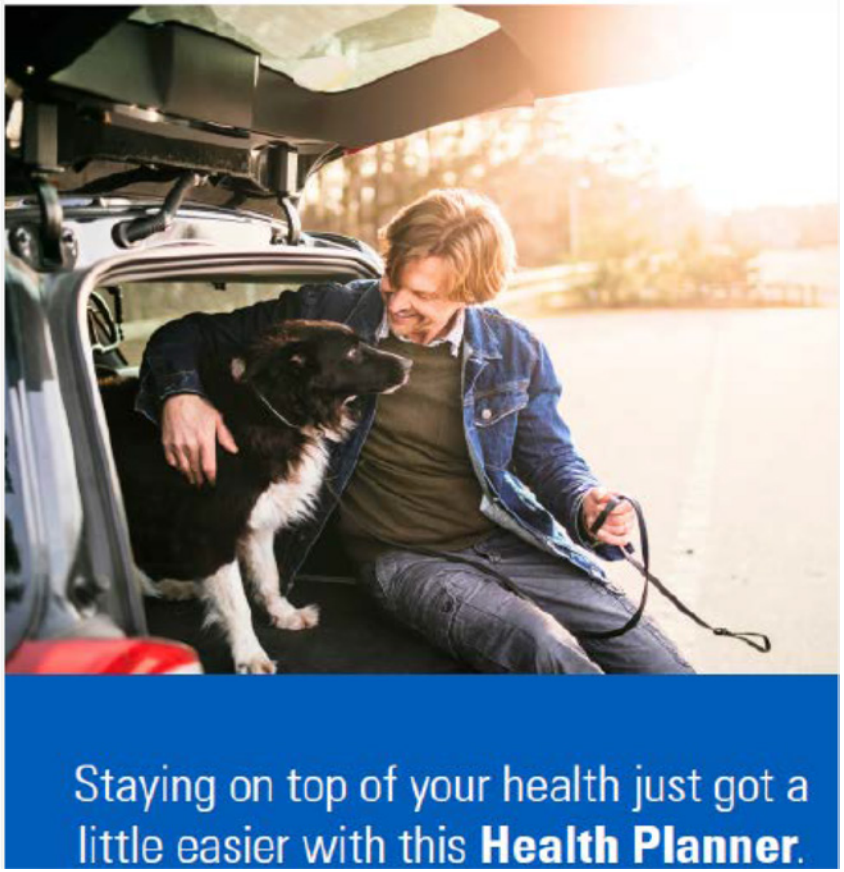
Needed screenings and health tips

Sample- HEALTH PLANNER Measures

Some measures apply only to certain insurance products based on National Committee for Quality Assurance recommendations

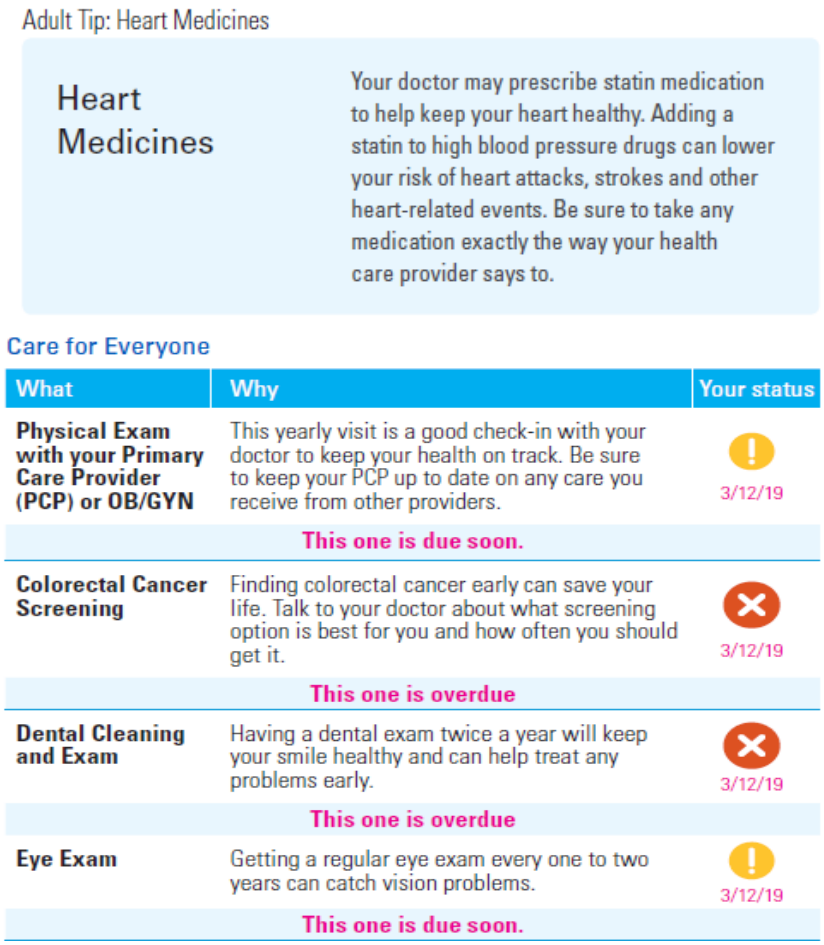
INDICATOR MEASURES	
Well-Child 0-6 years	Breast Cancer Screening
Adolescent Well-Care	Cervical Cancer Screening
Adult Annual Wellness	Colorectal Screening
Childhood Immunizations	Diabetic Eye Exam
Adolescent Immunizations	Diabetic Nephropathy
Dental Cleaning & Exam	Diabetic HbA1c
Eye Exam	Osteoporosis Management
Metabolic Testing	Drug Therapy for Rheumatoid Arthritis

HEALTH MESSAGES & TIPS	
Prenatal & Postpartum Care	Asthma
Low Back Pain	Appropriate Antibiotic Use
COPD Medication Adherence	ADHD Medication Follow up
Beta Blocker Medication Adherence	Drug & Alcohol Abuse Treatment
Controlling High Blood Pressure	Smoking & Tobacco Use Cessation
Statin Therapy	Mental Illness & Depression Follow-up
Transition from Pediatric to Adult Care	



Patient Health Planners

Needed screenings and health tips



Adult Tip: Heart Medicines

Heart Medicines

Your doctor may prescribe statin medication to help keep your heart healthy. Adding a statin to high blood pressure drugs can lower your risk of heart attacks, strokes and other heart-related events. Be sure to take any medication exactly the way your health care provider says to.

Care for Everyone

What	Why	Your status
Physical Exam with your Primary Care Provider (PCP) or OB/GYN	This yearly visit is a good check-in with your doctor to keep your health on track. Be sure to keep your PCP up to date on any care you receive from other providers.	3/12/19
	This one is due soon.	
Colorectal Cancer Screening	Finding colorectal cancer early can save your life. Talk to your doctor about what screening option is best for you and how often you should get it.	3/12/19
	This one is overdue	
Dental Cleaning and Exam	Having a dental exam twice a year will keep your smile healthy and can help treat any problems early.	3/12/19
	This one is overdue	
Eye Exam	Getting a regular eye exam every one to two years can catch vision problems.	3/12/19
	This one is due soon.	

- We let the patients know if care is **due soon, overdue** or **already done for the year** based on the status symbol color.
- A status indicator shows recommended health screenings:
  - **Red:** Screening is past due
  - **Yellow/Orange:** Screening is needed
  - Some may also include a **Green** status indicator to show that the member is up-to-date
- Details about the needed screenings and their purpose

Health Screening Events

Provider, community and patients

Diabetic Screenings

Colorectal Cancer Screenings

Breast Cancer Screenings

Customized On-Site Events

- Well-Care / Screening Events
- Community Outreach
- Patient Education

Targeted Member Education

- Telephonic outreach offering education and assistance with appointment scheduling for needed screenings
- Preventive Screening Campaigns
- Patient Brochures

Health Screening Events

Coordination and scheduling contacts

BlueCare Tennessee

1-800-771-0217

Commercial

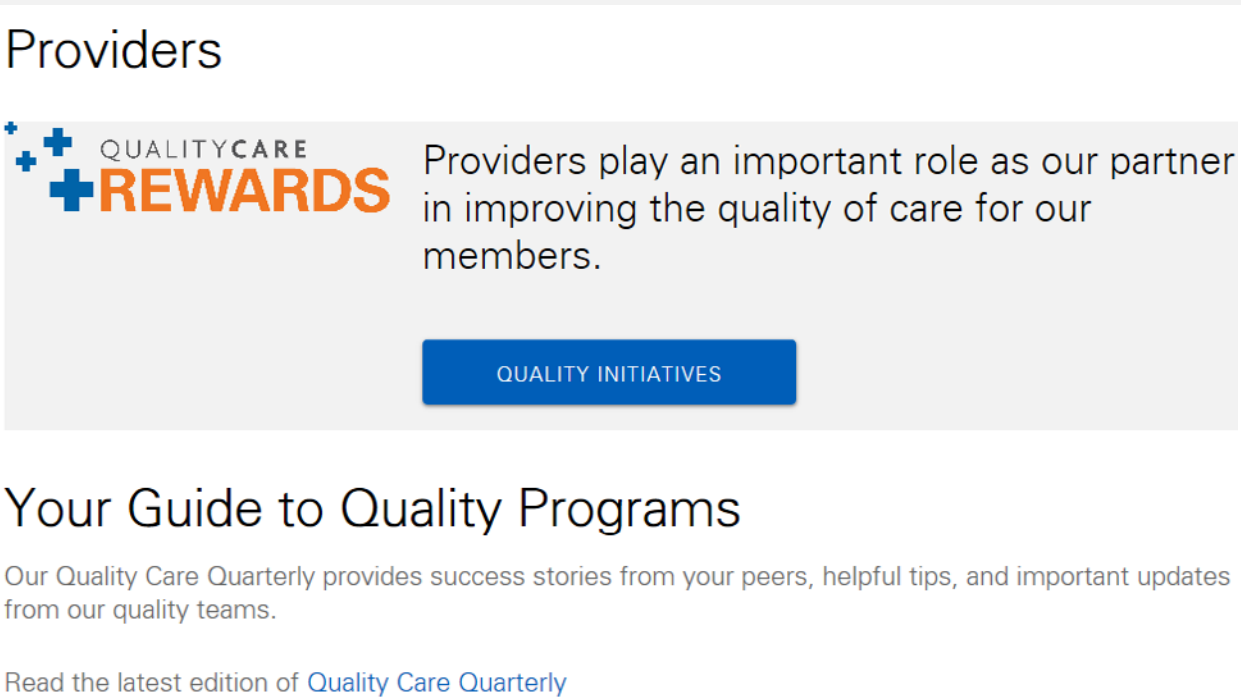
GM_Commercial_Quality_Improvement@bcbst.com

Medicare Advantage

Contact your Quality/Stars Team provider representative

Provider Resources

What's available?



- Newsletter articles about best practice tips for quality care, quality measure updates, scheduling routine care and more
- Quality Care Measure Guides provide information about closing gaps in care for members, documentation to meet guidelines, sample codes and tips

Provider Resources

Where can you find help?

BlueAlert Provider Newsletter

Our latest BlueAlert edition is available online.

- Download The Current Issue
- See the Archives

Tips for Coding Professionals

This information applies to all lines of business unless stated otherwise.

New CPT® Codes for Psychological and Neuropsychological Testing

Beginning Jan. 1, 2019, we're adopting the new CPT® codes for psychological and neuropsychological testing required by the American Medical Association (AMA). Please use them for all claims for dates of service as of Jan. 1, even if the tests were authorized prior to that date. You're welcome to amend or request a retroactive approval to your prior authorization request to include newly covered services (e.g. feedback sessions) if you submitted your request before Jan. 1.

Please note: If you don't use these new codes after Jan. 1, your claims will be denied. However, prior authorization requirements for these tests remain the same.

To order copies of the CPT® manual from the AMA, visit commerce.ama-assn.org/store or call 1-800-621-8335. If you have questions, please contact your regional Provider Network Manager.

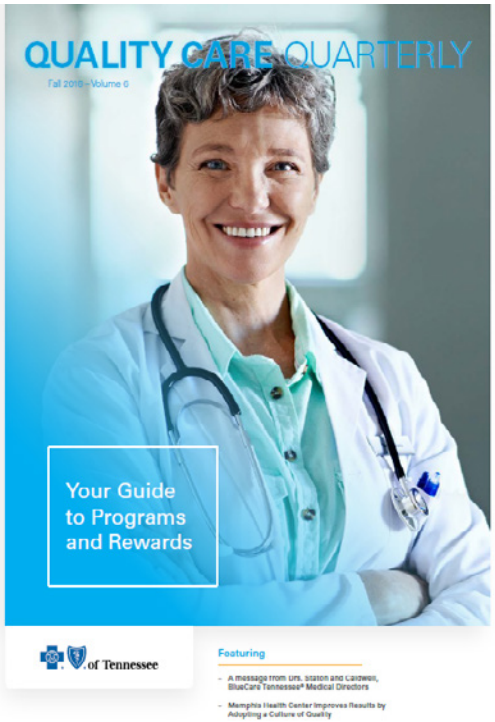
HCPCS G Codes No Longer Required for Physical and Occupational Therapy

Effective Jan. 1, 2019, in alignment with CMS, our BlueAdvantage and BlueCare Plus Medicare Advantage plans no longer require the reporting of functional status (G Codes) related to physical therapy and occupational therapy services. Claims processing and reimbursement will not be impacted if you still choose to file the G Codes.

Your Guide to Quality Programs

Our Quality Care Quarterly provides success stories from your peers, helpful tips, and important updates from our quality teams.

Read the latest edition of Quality Care Quarterly



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CAHPS Survey

Survey of perception & performance

What is CAHPS?

Consumer

Assessment of

Healthcare

Providers and

Systems

- CAHPS® is a family of surveys that measures topics important to members, such as communication skills of providers and the accessibility of services.
- CAHPS® is considered the national standard for measuring and reporting on consumers' experiences with health plans and their services.
- The CAHPS® surveys ask, "Are consumers satisfied with the quality of care and customer services provided by their health plan (such as BlueCross), and their providers?"
- CAHPS® provides a measurement of how our members (patients) perceive the care they receive from BlueCross-contracted doctors and providers.

How to Win at CAHPS

Survey of perception & performance

Your interaction with members has a direct impact on your patients' response to the CAHPS survey.

Remember: the CAHPS® survey measures the **member's *perception*** of the care they have received.

CAHPS

Survey of perception & performance

Incorporating the following simple techniques into your daily interactions with patients will provide them with a better experience, help them achieve better health outcomes and can lead to better patient retention.

- Providing timely appointments
- Discussing care received from the Emergency Department and other providers
- Ensuring follow-up to communicate test results
- Offering assistance for needed appointments with specialists
- Discuss current medications and address any barriers to getting needed medication
- Reviewing current medications from all providers

Enterprise Quality

Have Questions?

BlueCare Tennessee

BlueCare Tennessee

Transportation Services

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BlueCare

Transportation services

BlueCare Tennessee contracts with Southeastrans (SET) as the broker for Non-Emergency Medical Transportation. SET has recently changed their statewide phone numbers from three numbers to one. Please note, TennCare*Select* still has a separate phone number.

- BlueCare 1-855-735-4660
- TennCare*Select* 1-866-473-7565

BlueCare Tennessee

BlueCare

TennCare Kids – EPSDT

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BlueCare

TennCare Kids – membership and goals

BlueCare Tennessee provides health plans to more than 355,000 members under the age of 21.

- Our goal is to ensure each child receives appropriate health care
- This can be accomplished with your help through their TennCare Kids checkups

These services should be performed based on Bright Futures/American Academy of Pediatrics – *Recommendations for Preventive Pediatric Health Care*

BlueCare

TennCare Kids – we need your help

We Need Your Help			
Schedule appointments and provide reminders for patients.	Document all components of the exam in the patient's medical record.	Bill appropriately to maximize your reimbursement.	Convert sports physicals into Well-Care visits.
Pre-schedule newborn checkups.	Alternate and extended office hours.	Combining a Well-Care visit with other types of visits.	Assign staff specifically to handle Well-Care visits.

BlueCare

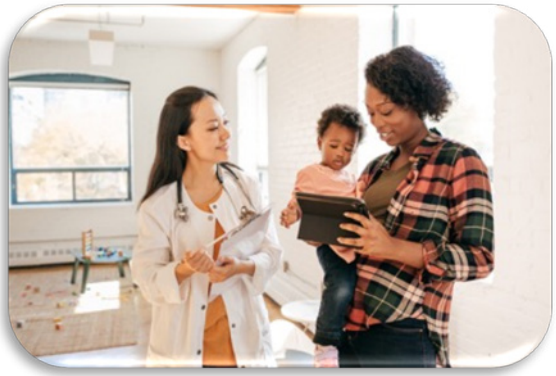
TennCare Kids – documenting care

Medical record documentation is very important

- Document all seven TennCare Kids exam components
- This includes refusals and uncooperative patients (document vaccine refusals with the AAP's Refusal to Vaccinate form at TNAAP.org)

TennCare Kids exam components:

- Comprehensive heath and developmental history
- Comprehensive unclothed physical exam
- Vision screening
- Hearing screening
- Laboratory tests/procedures
- Immunizations
- Health education/anticipatory guidance



BlueCare Tennessee

BlueCare

CoverKids

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CoverKids

What is it?

- Part of the federally sponsored Children's Health Insurance Program (CHIP), which provides health insurance to uninsured children.
- Provides free comprehensive health coverage for qualifying children 18 and younger and pregnant women.
- Not a Medicaid plan although it is administered by BlueCare Tennessee.

Who is Eligible?

Children

- Under the age of 19
- Tennessee resident
- Not eligible or enrolled in TennCare
- Meet household income requirements (at or below 250% of federal poverty level)

Pregnant Women

- Tennessee resident
- Not eligible or enrolled in TennCare
- Meet household income requirements (at or below 250% of federal poverty level)

CoverKids

Care coordination

- Ask your patient if they have received any services from other health care providers when you are providing treatment.
- Schedule annual appointments 12 months in advance.
- Assist members with appointment scheduling with specialists and other ancillary providers for procedures and tests.
- Any time children with CoverKids coverage are in your office, please make sure their checkups are up to date. Remember a sick visit could be your only chance for a CoverKids checkup.
- Encourage pregnant women to get the care they need during and after their pregnancy.

BlueCare Plus Tennessee

BlueCare Plus (HMO SNP)SM

HMO Dual Eligible Special Needs Plan (D-SNP)

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BlueCare Plus

What is a dual eligible special needs plan (D-SNP)

D-SNP is a special needs, Medicare Advantage plan serving people who are dual eligible for Medicare and Medicaid.

Who is eligible?

- Individuals who live in the plan service area of Tennessee
- Individuals who have both Medicare part A and B
- Individuals eligible for full Medicaid/TennCare benefits or Medicaid cost-sharing assistance under Medicaid/TennCare
  - FBDE (Full Benefit Dual Eligible)
  - QMB+/Only (Qualified Medicare Beneficiary)
  - SLMB+ (Specified Low Income Medicare Beneficiary)

BlueCare Plus Choice

Launch of the FIDE SNP

On Jan. 1, BlueCare Plus started offering a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP), BlueCare Plus Choice.

Members eligible for enrollment in the FIDE SNP must be:

- Current BlueCare Members
- Current BlueCare CHOICES Group 1, 2 or 3 Members; and
- Medicare eligible

*Other eligibility categories may become eligible at a later time.

For 2020, members enrolling in FIDE SNP will receive **the SAME benefits and services** they were previously receiving from BlueCare, BlueCare CHOICES and BlueCare Plus.

BlueCare Plus

DSNP vs. FIDE SNP: member experience

BlueCare Plus (DSNP)

- Members have multiple payers
- Members have multiple ID numbers
- Members have multiple entities coordinating care and services

BlueCare Plus Choice (FIDE SNP)

- Members will have a single payer
- Members will have a single ID number
- Members will have a single entity coordinating care and services

BlueCare Plus Choice

Impact to providers

- All provider services offered through BlueCare Plus are available for BlueCare Plus Choice.
- All existing provider processes for BlueCare Plus will remain the same for BlueCare Plus Choice.
- Claim adjudication may look different; reimbursement amounts will remain the same.
- Member incentives and provider incentives offered by BlueCare Plus will be offered for BlueCare Plus Choice as well.

BlueCare Plus

Four star achievement

BlueCare Plus

Important contacts

- Provider Service Line: 1-800-299-1407
  - 8 a.m.– 6 p.m. (ET), Monday through Friday
- BlueCare Plus website: bluecareplus.bcbst.com
- PACF/medical record fax: (423) 591-9504
- Utilization Management
  - Phone: 1-866-789-6314
  - Fax: 1-866-325-6698
- Barry Condra, Manager of Operations
  - Phone: (423) 535-7480
  - Email: Barry_Condra@bcbst.com

BlueCare Tennessee

BlueCare Quality

Improvement Strategies for HEDIS

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BlueCare

Targeted improvement strategies for HEDIS 2020

Follow-Up

Many treatment measures require timely follow-up. Focused effort on follow-up after discharge and ER visits and assistance making appointments is one key to success.

Medication Adherence

Medication adherence is an important part of member care. Outreach and provider notifications can help with encouraging members to continue using their medication or finding alternatives if side effects or finances become a barrier.

Behavioral Health

NCQA continues to add a behavioral health focus to their quality programs. Additionally, many of our members are in multiple measures and experience numerous events throughout the year. Coordination of care and continued support are necessary to impact these measures.

Provider Tools

Custom notifications, appointment scheduling, and member-level metrics can help providers manage member care related to medication adherence and follow-up care.

BlueCare

Follow-up measures

Measures would apply to pediatrics, family practice and adult medicine.

Follow up Measure	Age Groupings	Follow up Time Frame
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	6 – 12	Two or more visits within nine months (270 days)
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	6 years and older	Seven days and 30 days post-ED encounter Follow-up requires principal diagnosis of mental health disorder or self harm and mental health disorder
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	13 years and older	Seven days and 30 days post-ED encounter Follow-up requires principal diagnosis of AOD

Evidenced Based Guidelines
ADD: https://www.aafp.org/afp/2014/1001/p456.html
FUM: https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201400081
FUA: https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substanceuse.pdf

BlueCare

Medication adherence

Applies to family and adult medicine only

Medication Adherence Measure	Adherence
Antidepressant Medication Management (AMM)	6 months
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	80% of treatment period

Evidenced Based Guidelines
AMM: https://cpnp.org/guideline/external/depression; https://www.healthquality.va.gov/guidelines/MH/mdd/
SAA: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3805432/

Applies to pediatric, adult and family medicine

Measure	Age Groups	Lab or Service Needed
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	1-17 years	At least one glucose or HbA1c per measurement year At least one LDL-C or any other cholesterol test per measurement year
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	18-64 years	At least one glucose or HbA1c per measurement year
Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	1-17 years	Sometime between 90 days prior to the member filling the medication through 30 days after the member fills the medication

Evidenced Based Guidelines
APM: https://store.samhsa.gov/system/files/pep19-antipsychotic-bp.pdf
SSD: http://policylab.chop.edu/sites/default/files/PolicyLab_EtoA_Antipsychotic_Prescribing_to_Children_2015.pdf
APP: https://store.samhsa.gov/system/files/pep19-antipsychotic-bp.pdf; ttps://pediatrics.aappublications.org/content/143/1/e20183171; http://policylab.chop.edu/sites/default/files/PolicyLab_EtoA_Antipsychotic_Prescribing_to_Children_2015.pdf

BlueCare Tennessee

Have Questions?

BlueCross Performance Rating for PCPs

Directory Designation Initiative

ALL Blue 2020

A Tool to Help Members Navigate the Online Platform

Today reviews are available at the touch of a button, from Google to Yelp to social media posts, but not all information comes from a trusted source.

Our members are asking us for more tools to help them make informed decisions about their health care, including which doctor they want to see.

BlueCross Performance Rating

- Starting January 2020, we added a rating system to our public provider directory to help guide members looking for Primary Care Providers (PCPs) in Blue Network P℠ and/or Blue Network S℠. **This rating system is called the BlueCross Performance Rating.**
- The BlueCross Performance Rating complements our existing Patient Experience rating and helps balance subjective member feedback with objective claims data.

January 2020

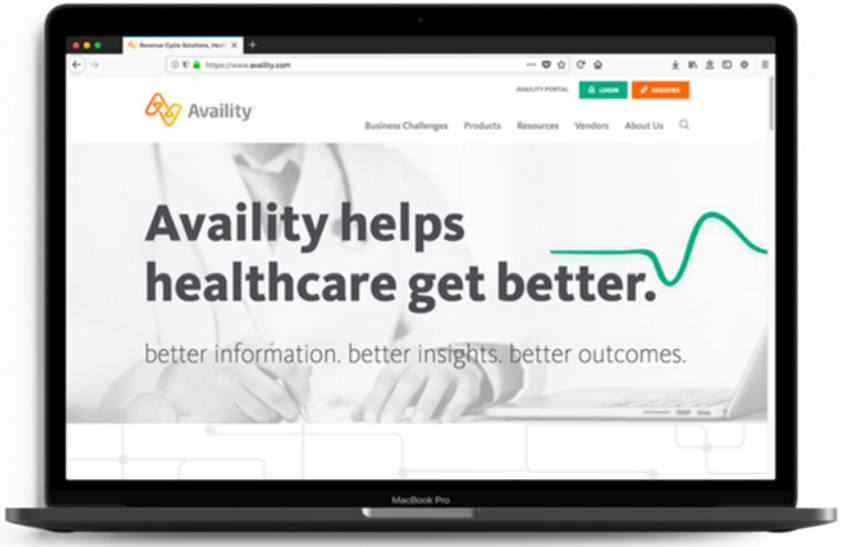
What is the BlueCross Performance Rating?

– The BlueCross Performance Rating scores PCPs on how well they deliver high-quality, high-value care. **It displays as a star rating, based on a five-point scale and is comprised of three weighted components:**

60%	20%	20%
Select HEDIS® measures used in the Quality Care Partnership Initiative (QCPI)	Efficient care delivery	Medical Home Partnership (MHP) participation

What is the HEDIS Quality Component?

- The quality component is based on each individual PCP's performance on measures from the Commercial QCPI program. These include how often a provider completes preventive screenings and follows treatment guidelines based on national HEDIS standards and National Committee Quality Assurance (NCQA) requirements.



- Providers who don't meet the minimum threshold show as "Not Yet Rated" in the directory.

- Use the Quality Care Rewards (QCR) application in Availity® to see your performance on HEDIS metrics.
  QCR is available even if you aren't participating in QCPI.

What is the Efficient Care Delivery Component?

- We use an analytics company called RowdMap to score providers, **using our claims data**, on the following four areas, based on how their practice patterns **compare to peers who practice in the same specialty and geographic region:**
  - Visits
  - Procedures
  - Prescriptions
  - Referrals

The overall composite score is an average of these four scores.

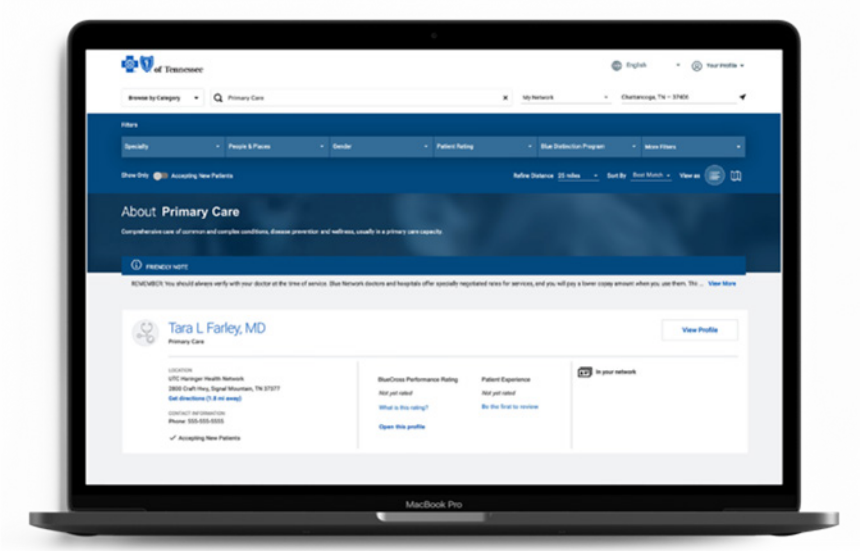
What is the Medical Home Partnership Component?

- Our Commercial Medical Home Partnership program (formerly Patient-Centered Medical Home) focuses on total population health with a goal of creating informed, engaged patients and prepared, proactive care teams.
  - Participating practices must achieve a minimum three-star rating in our QCPI program and maintain their NCQA PCMH Recognition.
- Providers who participate in our MHP program will earn the maximum score for the MHP component of the BlueCross Performance Rating. Providers who don't participate in our MHP program won't get any points for the MHP component and will display as "Not Participating" for this component.
  - **You can still achieve a five-star rating** with a strong performance in both the quality and efficient care delivery components, **even if you don't participate in the MHP program**.

Who Receives a Performance Rating?

- **If a PCP doesn't meet the minimum threshold requirement for a rating** (at least 30 attributed Commercial BlueCross patients), **we note that the provider is not yet rated instead of including stars.**

- **We refresh this performance rating each year, so providers have an opportunity to maintain or improve their scores by effectively managing their patient population.**



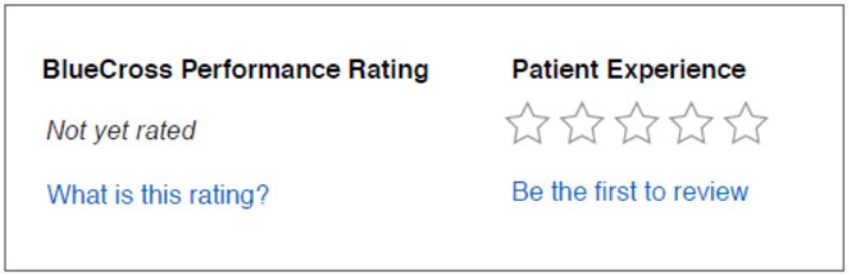
What Members See on the Search Results Page

PCPs With a Rating

- When members search for a PCP, the directory shows a side-by-side view of both the BlueCross Performance Rating, as well as the Patient Experience rating.

Images shown are prototypes and subject to modification.

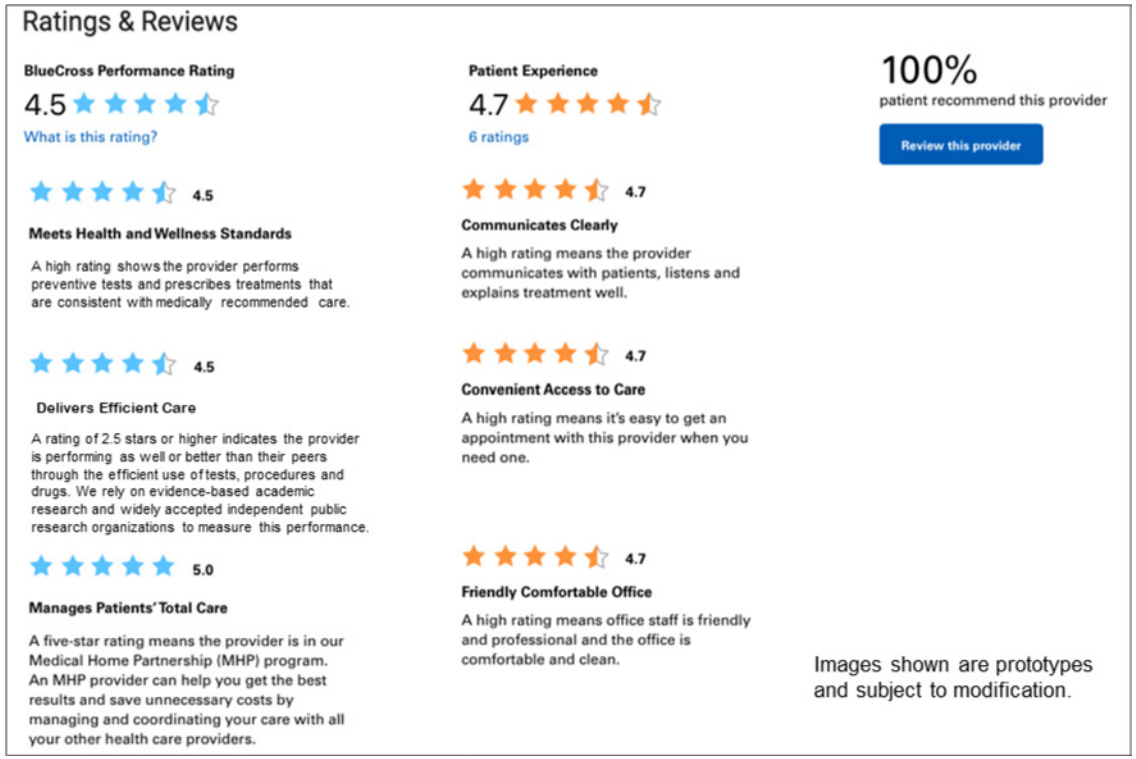
PCPs Without a Rating



- If a PCP doesn't meet the minimum threshold requirement or join the network following the annual calculation of ratings, we display "Not Yet Rated."
- Note: The Patient Experience rating shows transparent stars if there have been no reviews. Only members who have claims for the PCP in our system can leave a review.

What Members See on the Provider Profile

– The directory shows a **breakdown of the BlueCross Performance Rating under each provider's profile.** While members don't see the technical name of the components (e.g., HEDIS Quality), we do display a member-friendly description of each component:



Directory Designation

Have Questions?

Breakout Sessions

Provider Network Operations

Breakout Session

ALL Blue 2020

Provider Network Operations

- Provider Enrollment
- Data Verification and CAQH
- Consumer experience and communications

Provider Enrollment Process

ALL Blue 2020

Provider Enrollment With CAQH

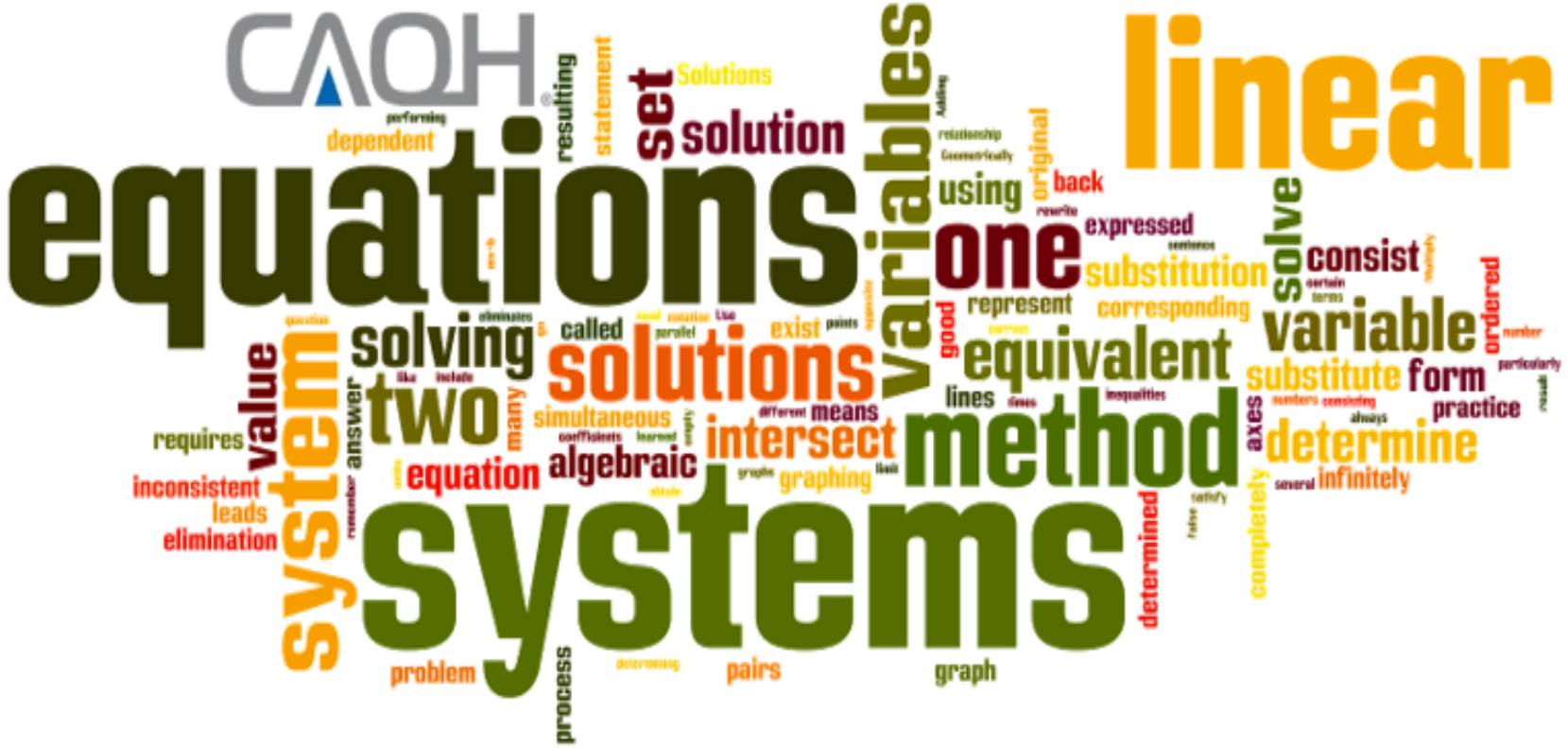
We are using a phased implementation approach:

Phase I – Complete
Is the CAQH ID valid?

Phase II – Complete
Is the provider record recently attested and in good standing?
Has the provider authorized BlueCross to receive their information?

Phase III – In process for first quarter 2020
Secure CAQH profile transfer in real time into our systems

Provider Data and the Council for Affordable Quality Healthcare (CAQH)



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Why Integrate Provider Enrollment With CAQH?

Increased Productivity

– Integrating with CAQH helps BlueCross employees complete tasks faster and without compromising quality.

Better Data Accuracy

– Duplicating data between CAQH and payer systems lowers overall quality and increases unnecessary noise. By reducing the need to duplicate data in multiple systems, we can also vastly lower the probability of human error.

Consistency Across Payers

– Working with CAQH allows for a more collaborative relationship between BlueCross and our provider groups so that our provider data is more consistent.

Why Integrate Provider Enrollment With CAQH?

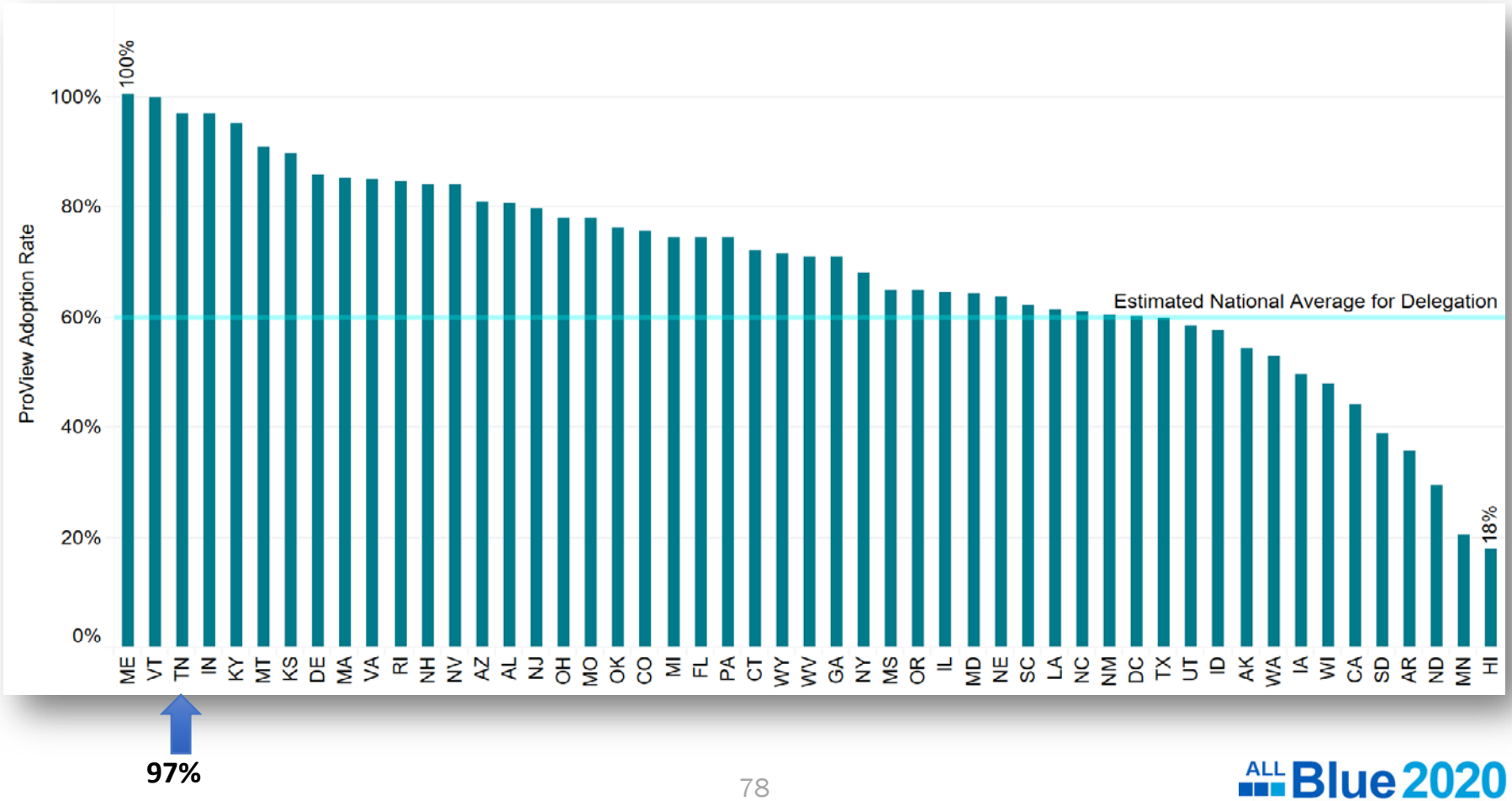
Organizational Readiness for Change

- By using tools that help BlueCross adapt to changing environments, we can more easily make adjustments to accommodate any potential changes to health care regulations.

Data Currency

- Being able to see data in real time allows us to see what the provider record looks like today and gives us insight into what is working well and what could be improved and changed.

Nationwide CAQH ProView Penetration



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Provider Stability Act – Overview

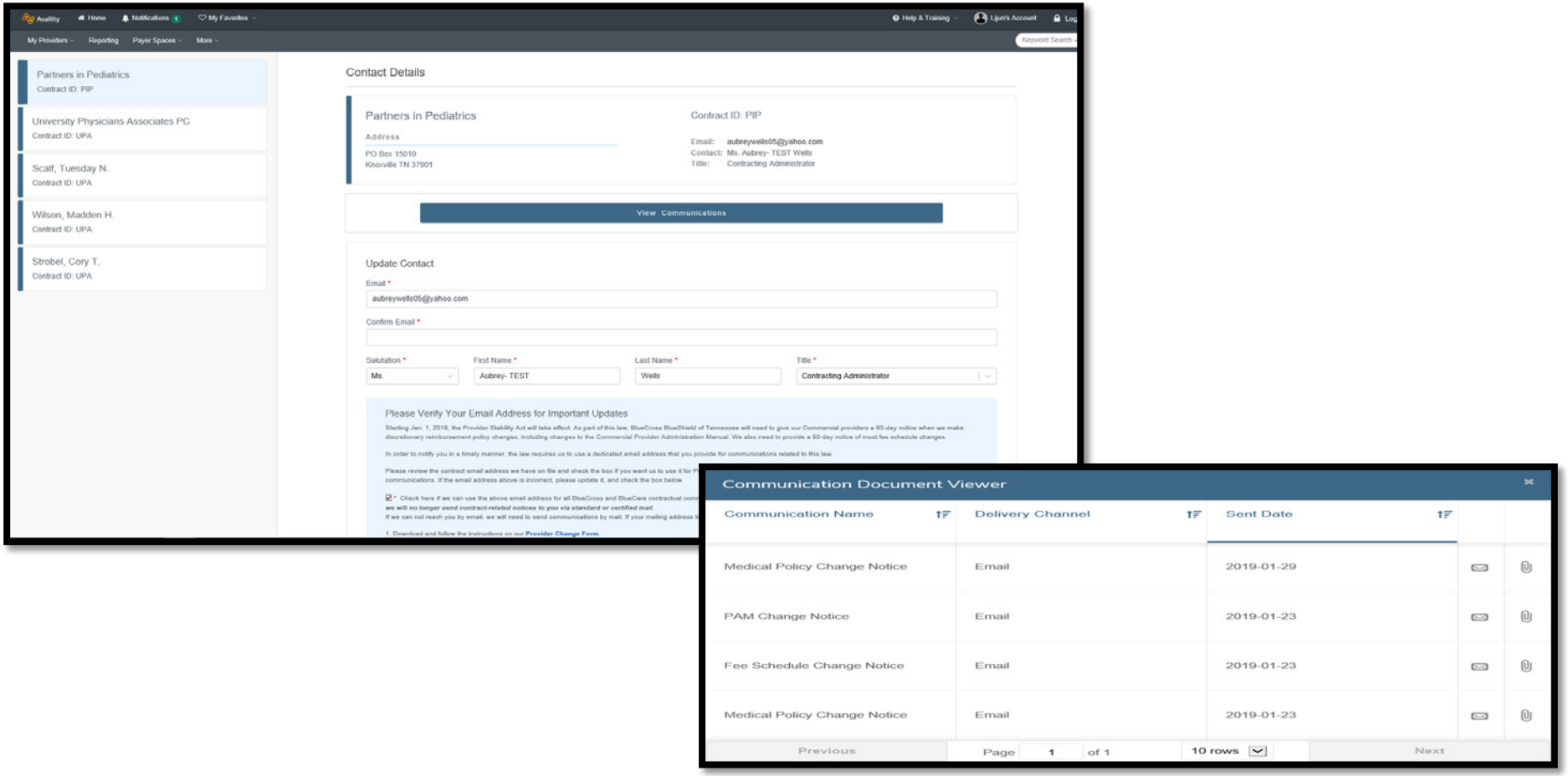
Insurer must tell providers about any:

– Material change to a previously released provider manual or a reimbursement rule and policy made at the sole discretion of the insurer at least 60 days before the effective date of change.
[Public Chapter No. 88 Section 1 (a)(1)]

– Change to a provider's fee schedule and the effective date of the change at least 90 days before the effective date of change.
[Public Chapter No. 88 Section 3 (1)]

- "Fee schedule" – a list of reimbursement amounts assigned to specific codes and used by a health insurance carrier according to a contract between a health insurance carrier and a health care provider to calculate payments paid to the provider for therapies, procedures, materials, and other services delivered to enrollees.
  [Public Chapter No. 88 Section 2 (2)]

PEACH – Contact Preferences & Communication Viewer



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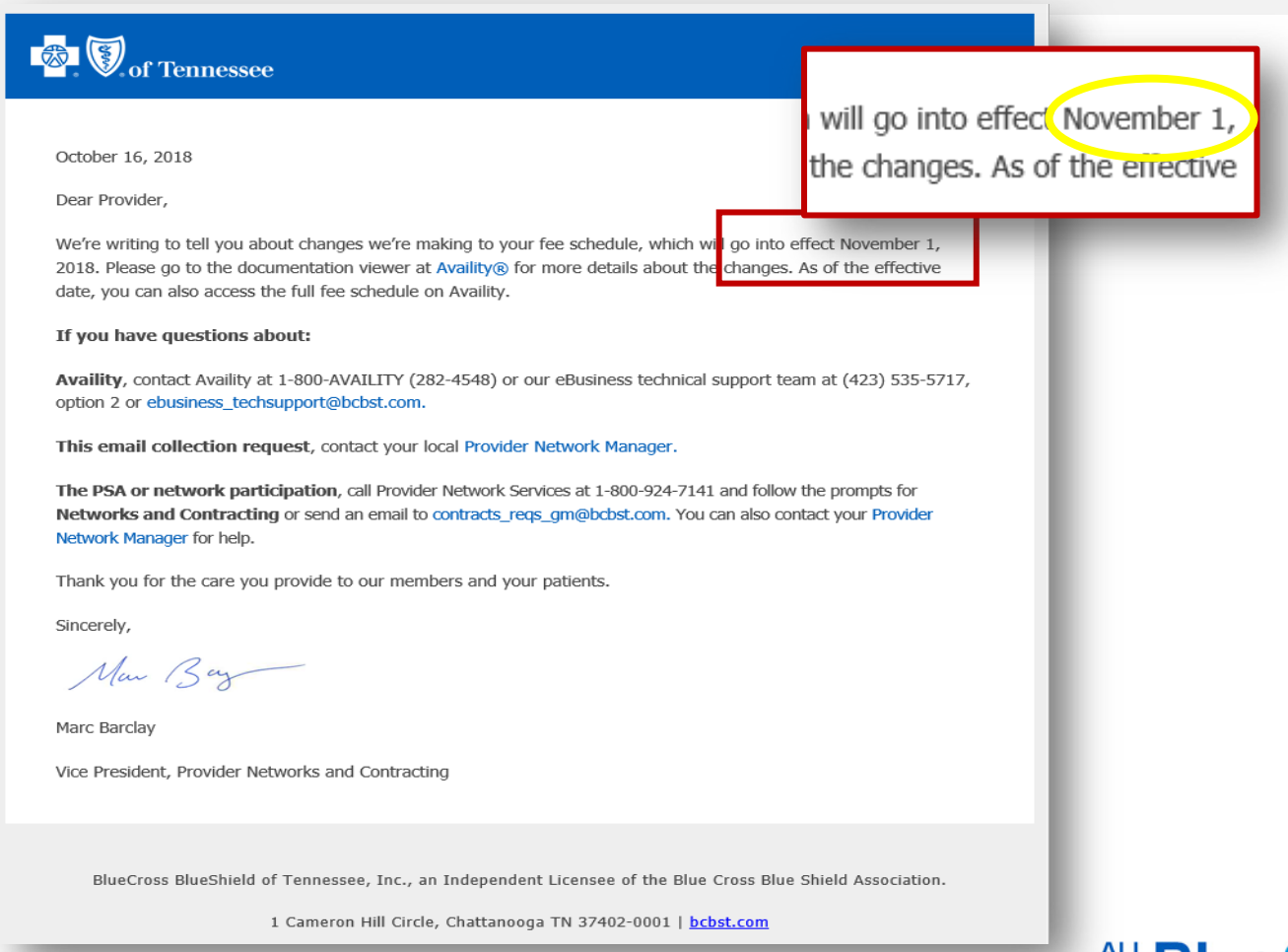
PEACH – Personalized Content



of Tennessee

October 16, 2018

Dear Provider,

We're writing to tell you about changes we're making to your fee schedule, which will go into effect November 1, 2018. Please go to the documentation viewer at Availity® for more details about the changes. As of the effective date, you can also access the full fee schedule on Availity.

If you have questions about:

Availity, contact Availity at 1-800-AVAILITY (282-4548) or our eBusiness technical support team at (423) 535-5717, option 2 or ebusiness_techsupport@bcbst.com.

This email collection request, contact your local Provider Network Manager.

The PSA or network participation, call Provider Network Services at 1-800-924-7141 and follow the prompts for **Networks and Contracting** or send an email to contracts_reqs_gm@bcbst.com. You can also contact your Provider Network Manager for help.

Thank you for the care you provide to our members and your patients.

Sincerely,

Marc Barclay

Vice President, Provider Networks and Contracting

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the Blue Cross Blue Shield Association.

1 Cameron Hill Circle, Chattanooga TN 37402-0001 | bcbst.com

will go into effect November 1, the changes. As of the effective

Provider Network Operations

Have Questions?

Commercial Quality

Breakout Session

ALL Blue 2020

Partners in the Pursuit of Health

A three-prong approach

- Member
- Provider
- Health Plan

Quality is never an accident.
It is always the **result of intelligent effort**.
— John Ruskin

Member Support and Education

Member Outreach Calls by Outreach Pharmacy Specialists

- Follow-Up Care for Children Prescribed ADHD Medications (ADD)
- Antidepressant Medication Management (AMM)
- Medication Management for People with Asthma (MMA)
- Pharmacotherapy Management of COPD Exacerbation (PCE)
- Statin Therapy for Patients with Cardiovascular Disease (SPC)
- Statin Therapy for Patients with Diabetes (SPD)
- Childhood Immunization Status (CIS)
- Immunizations for Adolescents (IMA)

Member Support and Education

Our Focus on Medication Adherence

We know you place an importance on educating patients on the benefits and risks of prescribed medication, and we're here to help. We have a dedicated team that contacts patients who are not getting their prescriptions refilled as they should. We work with patients, their providers and pharmacies to help address the reasons the patients aren't taking their medications as prescribed. Quality HEDIS measures included in our efforts are antidepressant, asthma, COPD, statin, ADD medications, and more.

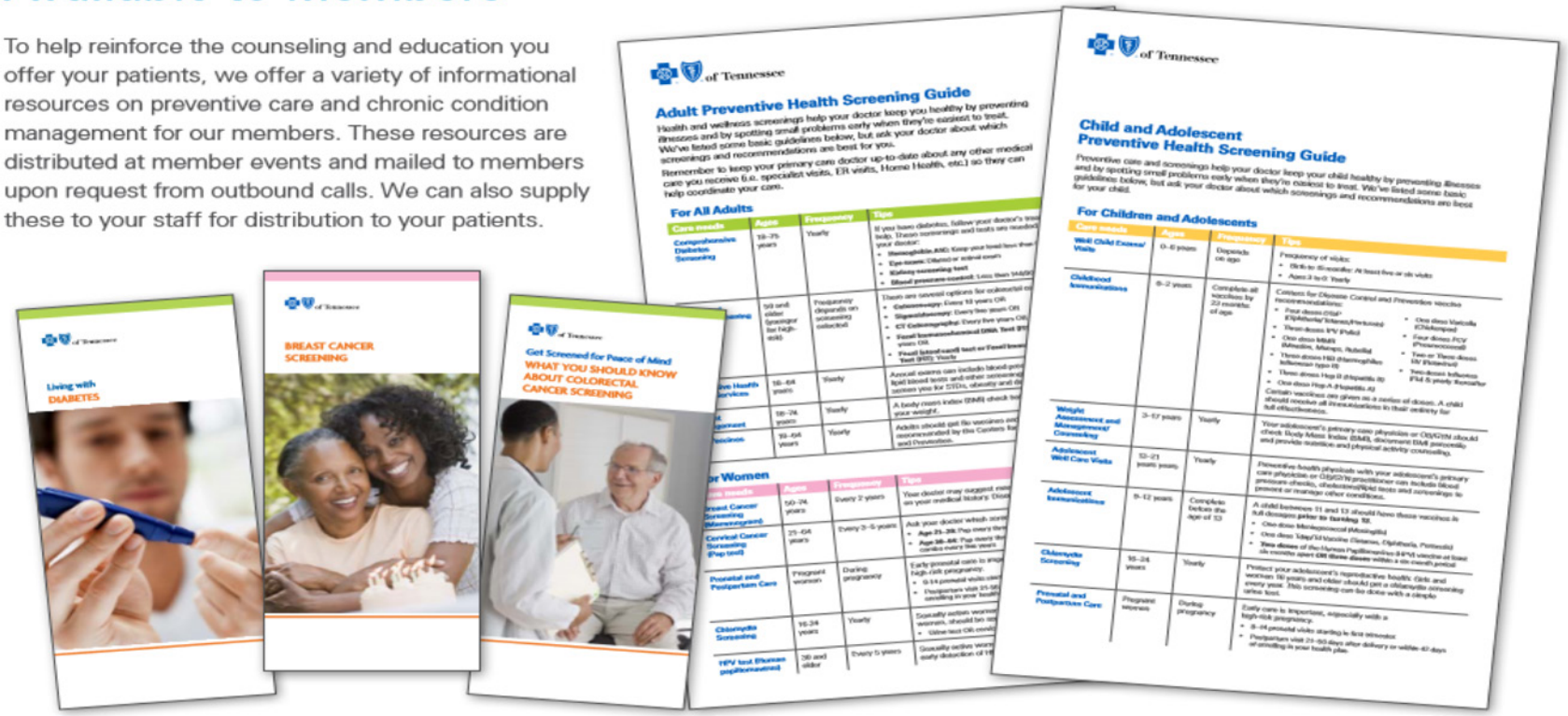
We've found these best-practices helpful to many of our members and their providers.

1. Write prescriptions the way you instruct your patients to take their medications.
2. Encourage patients on an established maintenance medication regimen to use mail-order and 90-day supply options.
3. Talk to your patients about the purpose of their medications and how they may make them feel.
4. Coordinate all prescription refills for the same time to help prevent gaps in therapy.
5. Suggest patients use pill boxes and set reminders for refills.
6. Schedule office visits and follow-up appointments prior to prescriptions running out.
7. Refer patients to our Care Management program, at **1-800-565-9140**, for assistance with other barriers to medication adherence. We have nurse case managers, social workers, and a dietitian available to help.

Member Support and Education

Health Education Resources Available to Members

To help reinforce the counseling and education you offer your patients, we offer a variety of informational resources on preventive care and chronic condition management for our members. These resources are distributed at member events and mailed to members upon request from outbound calls. We can also supply these to your staff for distribution to your patients.



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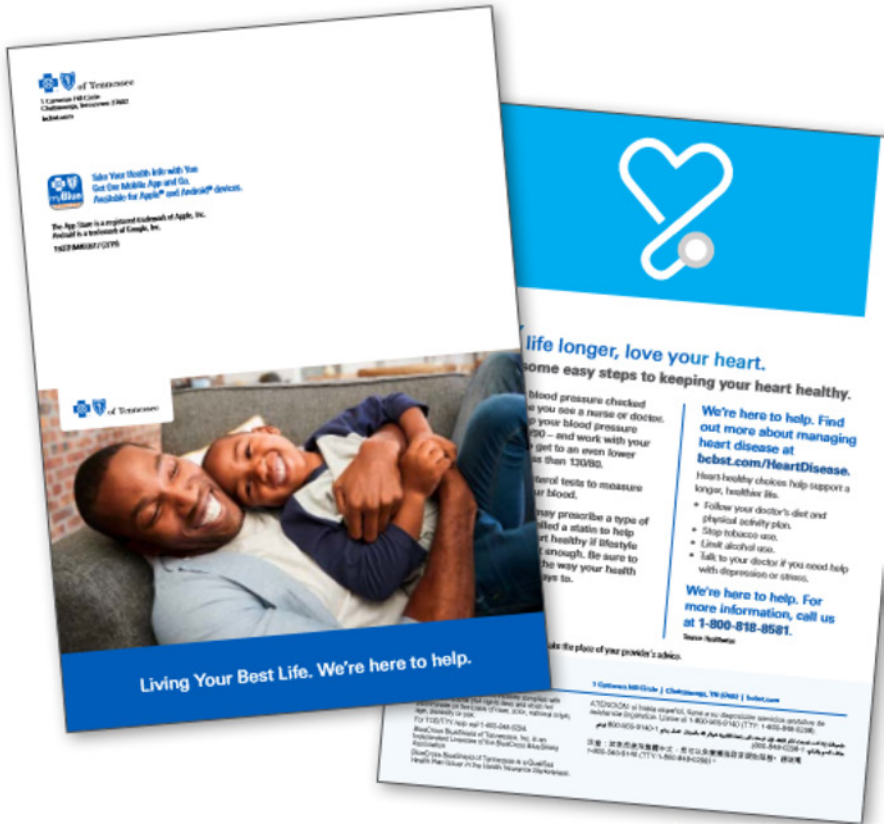
Member Support and Education

Outreach Campaigns to Targeted Members

Throughout the year, we identify members who may need preventive care, screenings or education on potential health issues, and send informative clinical messages to them through mail, email and automated phone calls. These campaigns include a focus on:

- COPD
- Immunizations
- Flu or pneumonia
- Appropriate antibiotic use
- CAD
- Colorectal cancer screening
- Low back pain
- Diabetes and statin use

Campaigns are also directed towards patients with chronic conditions to make them aware of their disease management benefits.



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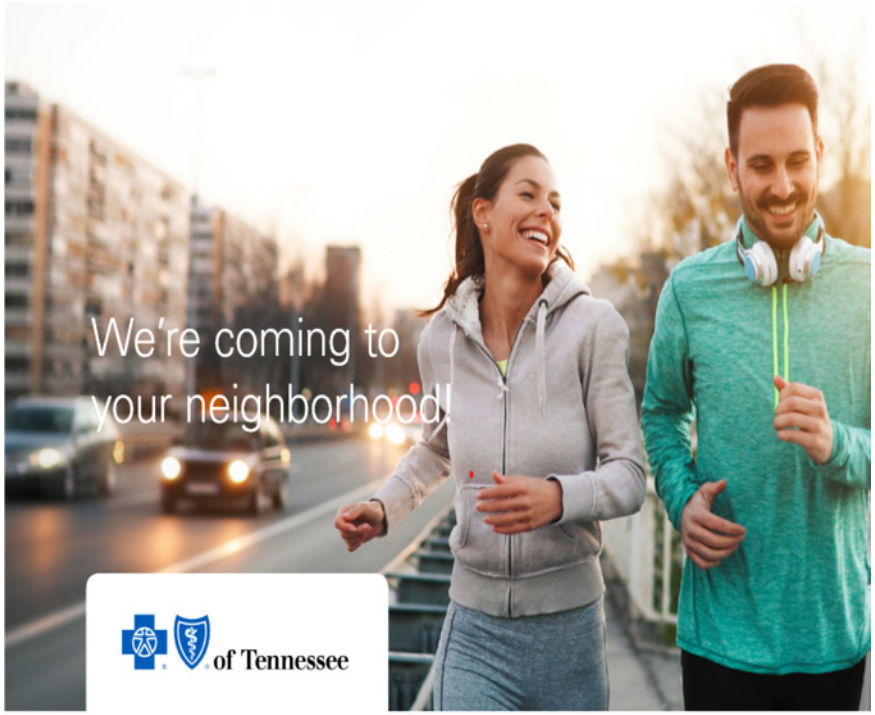
Member Wellness Events

Member Wellness Event Campaigns for 2019 included:

- Breast Cancer Screening
- Colon Cancer Screening
- Retinal Eye Exams
- Drive Through Flu Shot Clinics



ALL Blue 2020

Provider Support and Education

Assistance in Closing Quality Measures

Preventive care helps your patients improve their ability to lead healthy lives. But we know it's not always easy to get patients in the office for these important visits. That's why we give you other options for getting these screenings completed.

We offer customized onsite health screening events at your location tailored to best fit the needs of your office. Services we offer can include:

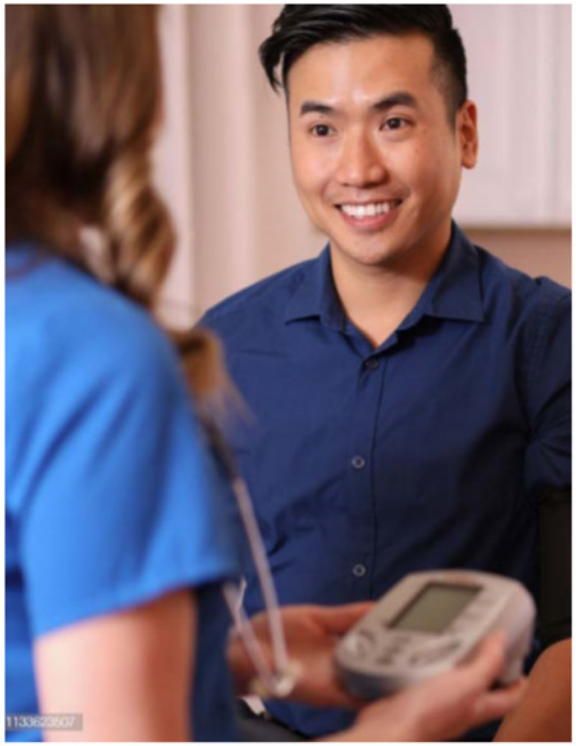
- Breast cancer screenings
- Diabetic retinal eye exams
- Colorectal cancer screenings

We identify members who could benefit from these screenings and schedule a convenient time for them. Our onsite events can also include community outreach and member education.

Our team will be onsite at your event to assist our vendor partners, provide support, answer questions and help educate your patients on the importance of prevention and screening tests. There is also the opportunity to conduct other services during the same visit, including:

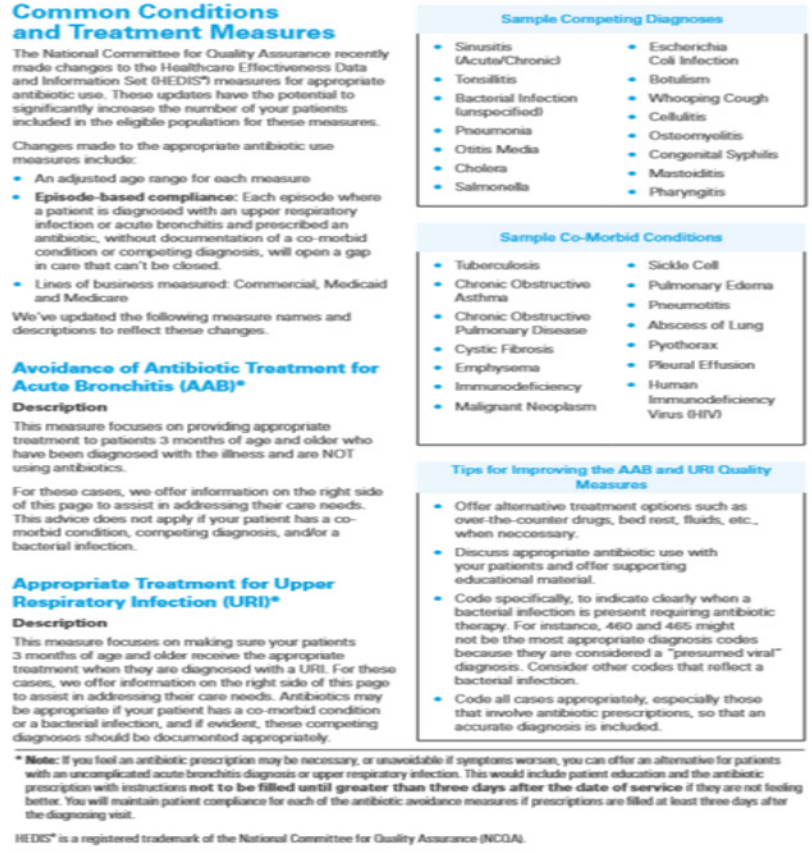
- Annual wellness visit
- BMI assessments
- Blood pressure checks

To schedule an event, contact us at GM_Commerical_Quality_Improvement@bcbst.com



Provider Outreach Initiatives

Provider educational brochure on Appropriate Antibiotic Use HEDIS measures, and letter & data tables



Common Conditions and Treatment Measures

The National Committee for Quality Assurance recently made changes to the Healthcare Effectiveness Data and Information Set (HEDIS®) measures for appropriate antibiotic use. These updates have the potential to significantly increase the number of your patients included in the eligible population for these measures.

Changes made to the appropriate antibiotic use measures include:

- An adjusted age range for each measure
- **Episode-based compliance:** Each episode where a patient is diagnosed with an upper respiratory infection or acute bronchitis and prescribed an antibiotic, without documentation of a co-morbid condition or competing diagnosis, will open a gap in care that can't be closed.
- Lines of business measured: Commercial, Medicaid and Medicare

We've updated the following measure names and descriptions to reflect these changes.

Avoidance of Antibiotic Treatment for Acute Bronchitis (AAB)*

Description

This measure focuses on providing appropriate treatment to patients 3 months of age and older who have been diagnosed with the illness and are NOT using antibiotics.

For these cases, we offer information on the right side of this page to assist in addressing their care needs. This advice does not apply if your patient has a co-morbid condition, competing diagnosis, and/or a bacterial infection.

Appropriate Treatment for Upper Respiratory Infection (URI)*

Description

This measure focuses on making sure your patients 3 months of age and older receive the appropriate treatment when they are diagnosed with a URI. For these cases, we offer information on the right side of this page to assist in addressing their care needs. Antibiotics may be appropriate if your patient has a co-morbid condition or a bacterial infection, and if evident, these competing diagnoses should be documented appropriately.

Sample Competing Diagnoses

- Sinusitis (Acute/Chronic)
- Tonsillitis
- Bacterial Infection (unspecified)
- Pneumonia
- Otitis Media
- Cholera
- Salmonella
- Escherichia Coli Infection
- Botulism
- Whooping Cough
- Cellulitis
- Osteomyelitis
- Congenital Syphilis
- Mastoiditis
- Pharyngitis

Sample Co-Morbid Conditions

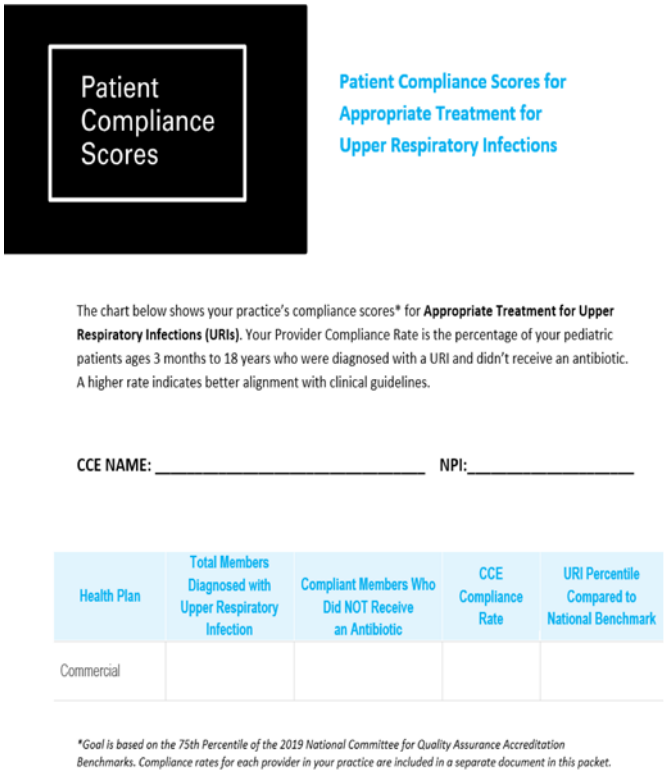
- Tuberculosis
- Chronic Obstructive Asthma
- Chronic Obstructive Pulmonary Disease
- Cystic Fibrosis
- Emphysema
- Immunodeficiency
- Malignant Neoplasm
- Sickle Cell
- Pulmonary Edema
- Pneumotitis
- Abscess of Lung
- Pyothorax
- Pleural Effusion
- Human Immunodeficiency Virus (HIV)

Tips for Improving the AAB and URI Quality Measures

- Offer alternative treatment options such as over-the-counter drugs, bed rest, fluids, etc., when necessary.
- Discuss appropriate antibiotic use with your patients and offer supporting educational material.
- Code specifically, to indicate clearly when a bacterial infection is present requiring antibiotic therapy. For instance, 460 and 465 might not be the most appropriate diagnosis codes because they are considered a "presumed viral" diagnosis. Consider other codes that reflect a bacterial infection.
- Code all cases appropriately, especially those that involve antibiotic prescriptions, so that an accurate diagnosis is included.

* **Note:** If you feel an antibiotic prescription may be necessary, or unavoidable if symptoms worsen, you can offer an alternative for patients with an uncomplicated acute bronchitis diagnosis or upper respiratory infection. This would include patient education and the antibiotic prescription with instructions **not to be filled until greater than three days after the date of service** if they are not feeling better. You will maintain patient compliance for each of the antibiotic avoidance measures if prescriptions are filled at least three days after the diagnosing visit.

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



Patient Compliance Scores

Patient Compliance Scores for Appropriate Treatment for Upper Respiratory Infections

The chart below shows your practice's compliance scores* for **Appropriate Treatment for Upper Respiratory Infections (URIs)**. Your Provider Compliance Rate is the percentage of your pediatric patients ages 3 months to 18 years who were diagnosed with a URI and didn't receive an antibiotic. A higher rate indicates better alignment with clinical guidelines.

CCE NAME: _____ **NPI:** _____

Health Plan	Total Members Diagnosed with Upper Respiratory Infection	Compliant Members Who Did NOT Receive an Antibiotic	CCE Compliance Rate	URI Percentile Compared to National Benchmark
Commercial				

*Goal is based on the 75th Percentile of the 2019 National Committee for Quality Assurance Accreditation Benchmarks. Compliance rates for each provider in your practice are included in a separate document in this packet.

Provider Outreach Initiatives

2019 low back pain initiative

Clinical face-to-face visits with high-volume, low-compliance providers statewide:

- Hot/cold packs for symptomatic relief for members
- Provider letter including compliance data
- Pocket-size card indicating “Red Flags”
- Choosing Wisely low back pain posters for exam rooms
- Member educational brochures

CAHPS Survey

The member's perception of their health care team

Provider rating is based on the member's perception of the provider's ability to:

- Provide timely appointments and care
- Communicate information at the member's level
- Coordinate patient's care by using information and reports from other provider visits
- Employ a helpful, courteous and respectful office staff

Your Commercial Quality Improvement Team

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Commercial Quality

Have Questions?

BlueCare Tennessee

Tennessee Healthcare Innovation Initiative (THCII): Episodes of Care

Breakout Session

ALL Blue 2020

THCII Episodes of Care

Agenda

- Episodes of Care Overview
- Reporting
- Thresholds
- Gain/Risk Sharing
- Provider Resources
- Reconsideration/Appeals
- Episodes of Care Changes

THCII Episodes of Care

Overview

- More information: tn.gov/tenncare/health-care-innovation/episodes-of-care.html

- The State determines the following:
  - The quarterback for an episode
  - The detailed business requirements for each episode
  - The reporting parameters and requirements
  - The acceptable thresholds

- There are currently 48 episodes spread out over nine waves.

- Reports on quality and cost performance are released quarterly in Availity, with a final report delivered in August of the year after the performance period, which shows if the provider has a payout, recoupment or neither.

THCII Episodes of Care

Reporting

The invoice will be the first page on the final reports published in Availity during August.

Depending on how the quarterback performs, they will receive one of the following invoices:

BlueCare Tennessee
1 Cameron Hill Circle
Chattanooga, TN 37402-0001
bluecare.bcbst.com

BlueCare℠ TennCareSelect CoverKids

Prepared for:

FINAL REPORT

August 2019

Description:	Total Gain/Risk Share:
Tennessee Health Care Innovation Initiative - Episodes of Care	$0

Performance Period:
01/01/2018 – 12/31/2018

As stipulated in your contract, provider groups with Episodes of Care whose average cost is lower than the threshold amount are owed a shared-savings payment. For 2018, your episode costs were either between the commendable and acceptable thresholds, or if below the commendable level, they did not meet the quality thresholds. Therefore, as stipulated in your contract, you are not due a shared-savings reward or required to pay a risk-share.

We would like to work with all providers in our network so that everyone can be successful in episodes, and in the future we hope to be paying a shared-savings reward to you. If you have any questions, or would like to talk with us about how you can affect your episode costs, please call us at 1-800-924-7141 or visit our website at the link below:

http://bluecare.bcbst.com/Providers/Provider-Education-and-Resources/THCII.html

BlueCross BlueShield of Tennessee and BlueCare Tennessee, Independent Licensees of the BlueCross BlueShield Association

1

As outlined in your contract, provider groups with Episodes of Care whose average cost is above the set acceptable threshold must pay a risk-share. For 2018, your average episode costs were above the acceptable threshold that triggers shared risk-share, and, therefore, the amount shown above is owed. We would like to work with all participating Quarterbacks in our network so that everyone can be successful in the Episodes of Care program.

Based on the 2018 performance period, you would owe a risk share so long as the amount owed shown on this invoice is over $100. Please do not remit payment back to BlueCross BlueShield of Tennessee if this invoice shows a total of $100 or less. In the future, we hope to pay a gain share reward to you.

Please send payment to:

BlueCross BlueShield of Tennessee
Attn: THCII Refunds
1 Cameron Hill Circle
Chattanooga, TN 37402

If payment is not sent within 60 days of your THCII remittance posting on BlueAccess, it will be deducted from future claims payments. If you have any questions or would like to talk with us about how you can affect your episode costs, please call us at 1-800-924-7141 or visit our website at the link below:

http://bluecare.bcbst.com/Providers/Provider-Education-and-Resources/THCII.html

As outlined in your contract, provider groups will receive a gain share payment when the group's average cost of Episodes of Care is below the set commendable threshold and when quality thresholds are met. For 2018, your average episode costs were below the commendable threshold, and you met quality thresholds. You will be paid the amount above and your remittance advice will be posted on BlueAccess, the secure portal on bluecare.bcbst.com. We would like to work with all participating Quarterbacks in our network so that everyone can be successful in the Episodes of Care program. Based on your episodes in 2018, you earned the shared gain amount indicated on this statement.

We hope to continue paying such rewards to you in the future. If you have any questions, or would like to talk with us about how you can affect your episode costs, please call us at 1-800-924-7141 or visit our website at the link below:

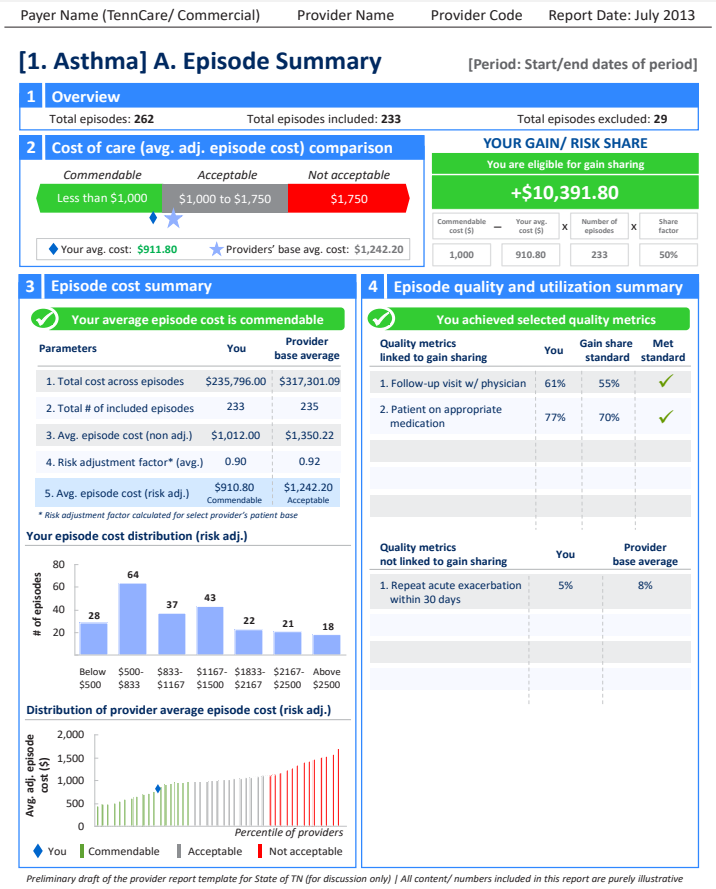
http://bluecare.bcbst.com/Providers/Provider-Education-and-Resources/THCII.html

THCII Episodes of Care

Reporting

Quarterbacks Receive Quarterly Reports:

- **Performance summary**
  - Total number of episodes (included and excluded)
  - Quality thresholds achieved
  - Average non-risk adjusted and risk adjusted cost of care
  - Cost comparison to other providers along with gain and risk sharing thresholds
  - Gain sharing, risk sharing eligibility, and calculated amounts
- **Quality detail:** Scores for each quality metric with comparison to gain share standard, or provider base average
- **Cost detail:**
  - Breakdown of episode cost by care category
  - Benchmarks against provider base average
- **Episode detail:**
  - Cost detail by care category for each individual episode a provider treats
  - Reason for any episode exclusions



Payer Name (TennCare/ Commercial) | Provider Name | Provider Code | Report Date: July 2013

[1. Asthma] A. Episode Summary [Period: Start/end dates of period]

1 Overview

Total episodes: **262** | Total episodes included: **233** | Total episodes excluded: **29**

2 Cost of care (avg. adj. episode cost) comparison

Commendable	Acceptable	Not acceptable
Less than $1,000	$1,000 to $1,750	$1,750

Your avg. cost: $911.80 | Providers' base avg. cost: $1,242.20

YOUR GAIN/ RISK SHARE

You are eligible for gain sharing

+$10,391.80

Commendable cost ($)	–	Your avg. cost ($)	x	Number of episodes	x	Share factor
1,000		910.80		233		50%

3 Episode cost summary

Your average episode cost is commendable

Parameters	You	Provider base average
1. Total cost across episodes	$235,796.00	$317,301.09
2. Total # of included episodes	233	235
3. Avg. episode cost (non adj.)	$1,012.00	$1,350.22
4. Risk adjustment factor* (avg.)	0.90	0.92
5. Avg. episode cost (risk adj.)	$910.80 Commendable	$1,242.20 Acceptable

* Risk adjustment factor calculated for select provider's patient base

Your episode cost distribution (risk adj.)

Distribution of provider average episode cost (risk adj.)

4 Episode quality and utilization summary

You achieved selected quality metrics

Quality metrics linked to gain sharing	You	Gain share standard	Met standard
1. Follow-up visit w/ physician	61%	55%	✓
2. Patient on appropriate medication	77%	70%	✓

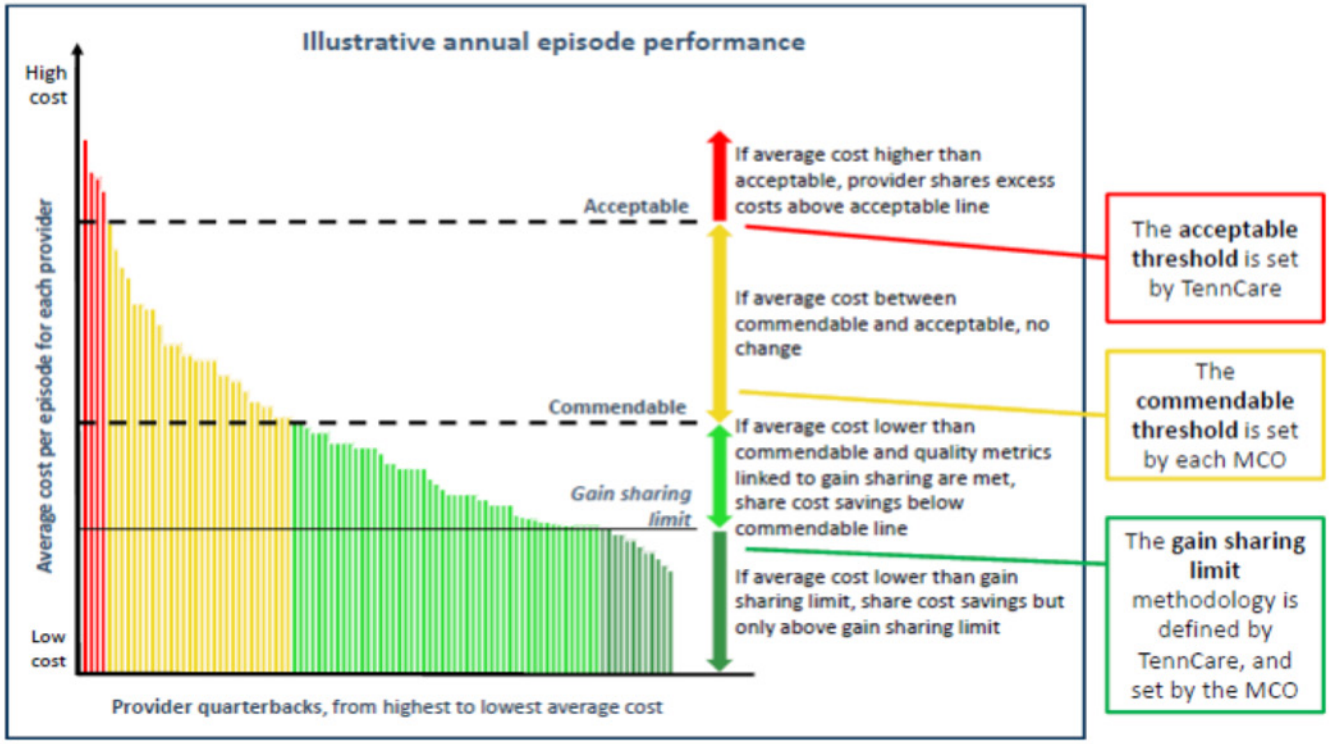
Quality metrics not linked to gain sharing	You	Provider base average
1. Repeat acute exacerbation within 30 days	5%	8%

Preliminary draft of the provider report template for State of TN (for discussion only) | All content/ numbers included in this report are purely illustrative

THCII Episodes of Care

Thresholds

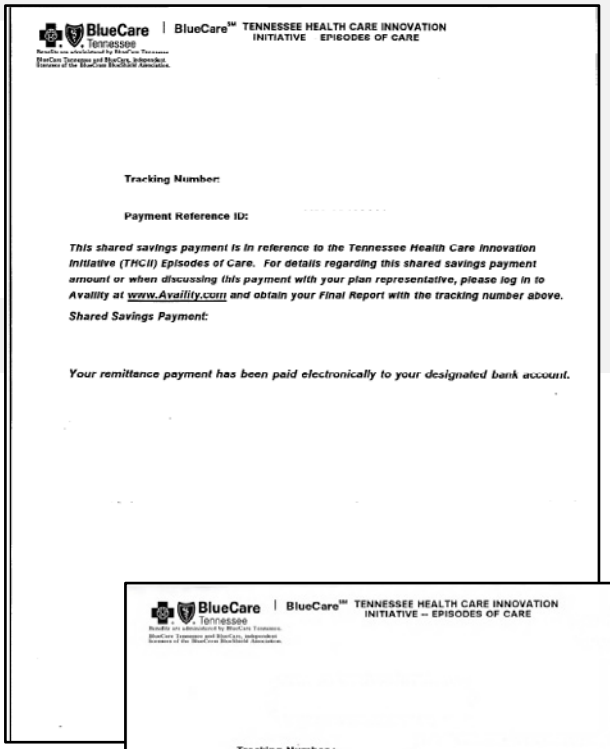
THRESHOLDS: ILLUSTRATIVE EXAMPLE



THCII Episodes of Care

Gain/risk share

- BlueCross will distribute payments via Electronic Funds Transfer (EFT).
- In the event of a risk share or recoupment, providers will be given a time limit to respond with payment and instructions.
- In August of each year, providers will receive final invoices for the previous year's performance.
- In December, payments and remits for recoupments will be sent out.



BlueCare Tennessee | BlueCare℠ TENNESSEE HEALTH CARE INNOVATION INITIATIVE EPISODES OF CARE

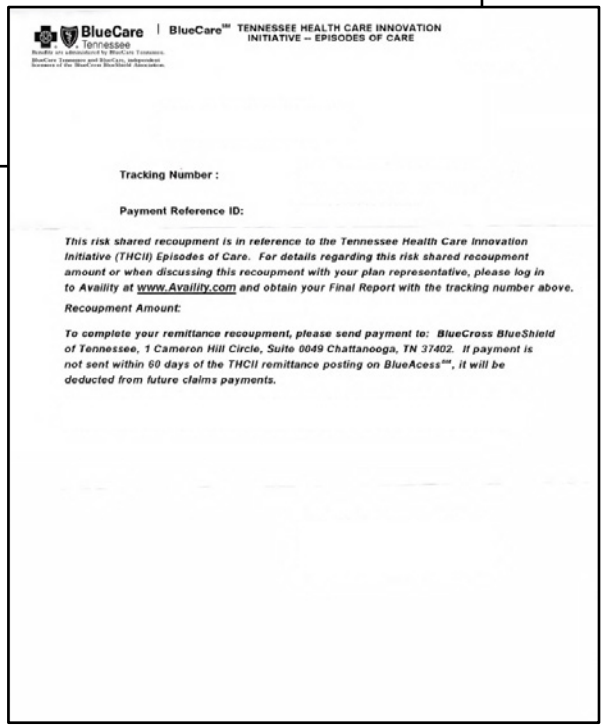
Tracking Number:

Payment Reference ID:

This shared savings payment is in reference to the Tennessee Health Care Innovation Initiative (THCII) Episodes of Care. For details regarding this shared savings payment amount or when discussing this payment with your plan representative, please log in to Availity at www.Availity.com and obtain your Final Report with the tracking number above.

Shared Savings Payment:

Your remittance payment has been paid electronically to your designated bank account.



BlueCare Tennessee | BlueCare℠ TENNESSEE HEALTH CARE INNOVATION INITIATIVE – EPISODES OF CARE

Tracking Number :

Payment Reference ID:

This risk shared recoupment is in reference to the Tennessee Health Care Innovation Initiative (THCII) Episodes of Care. For details regarding this risk shared recoupment amount or when discussing this recoupment with your plan representative, please log in to Availity at www.Availity.com and obtain your Final Report with the tracking number above.

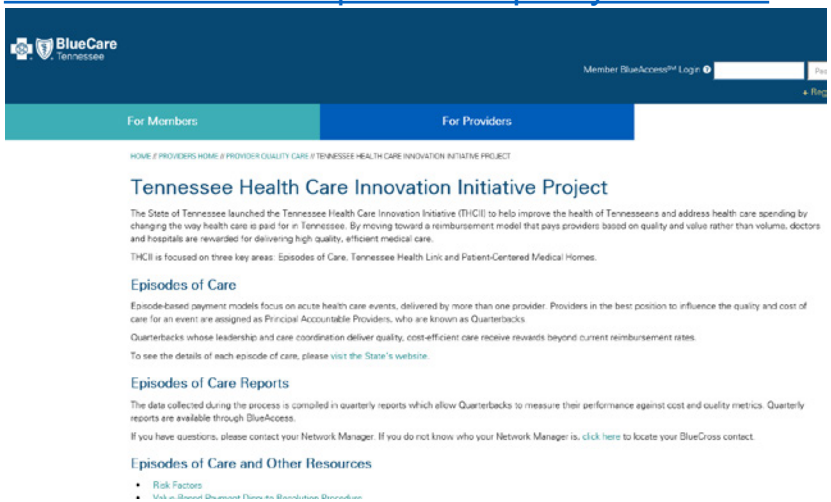
Recoupment Amount:

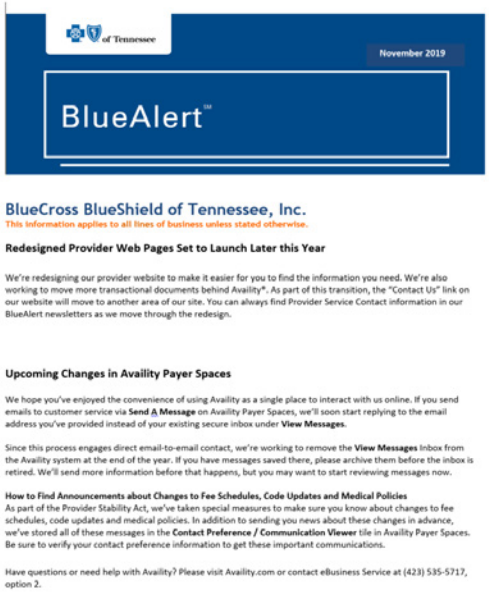
To complete your remittance recoupment, please send payment to: BlueCross BlueShield of Tennessee, 1 Cameron Hill Circle, Suite 0049 Chattanooga, TN 37402. If payment is not sent within 60 days of the THCII remittance posting on BlueAcess℠, it will be deducted from future claims payments.

THCII Episodes of Care

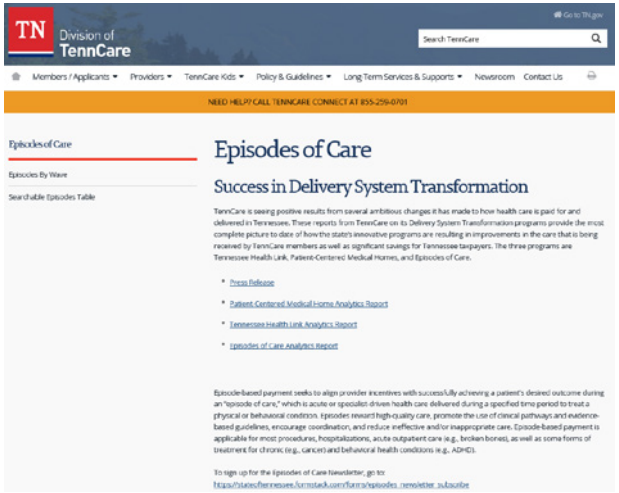
Provider resources

bluecare.bcbst.com/providers/quality-care/thcii





https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care.html



THCII Provider Guide:

- **The THCII Provider Guide can be found in our Provider Administration Manual.**
- **It includes important information about the design of the program, focusing initially on the Episodes of Care strategy.**
- **This guide also offers resources to help health care providers understand how the program impacts their organization.**
- **A link to the THCII Provider Guide can be found on the Bluecare website.**

THCII Episodes of Care

Reconsideration/appeals

Providers have the opportunity to dispute results as quarterly reports are published by submitting a reconsideration. An appeal can be submitted only after the Final Reports are published.

Episodes of Care and Other Resources

- Risk Factors
- Value-Based Payment Dispute Resolution Procedure
  - Value-Based Payment Dispute Resolution Forms
- THCII Provider Guide
- FAQs
- 2017 Thresholds
- 2018 Thresholds
- 2019 Thresholds
- Gain Share Limits
- Risk Adjustment
- State of Tennessee THCII Resources
  - www.tn.gov/tenncare/health-care-innovation.html
  - www.tn.gov/tenncare/health-care-innovation/stakeholder-presentations.html
  - Email: payment.reform@tn.gov

The Value-Based Payment Dispute Resolution Procedure and Forms are located on the BlueCare website

THCII Episodes of Care

Episodes of Care Changes

The memo's cover recommendations and corresponding improvements made to the Episodes of Care program for the 2019 and 2020 performance periods are based on physician feedback.

Improvements include, but are not limited to:

- Perinatal
- Low-volume exclusions
- Pharmacy costs
- Exclude patients who have high-cost comorbidities
- Overlapping episode exclusions

MEMO: 2020 Episode Changes

Introduction

Date: September 2019
Subject: Updates to TennCare's Episodes of Care program

This memorandum discusses the recommendations and state responses made to TennCare's Episodes of Care program in Tennessee for the 2020 performance period that begins January 1, 2020.

The state greatly appreciates the feedback we have received from stakeholders over the past year, and especially those stakeholders who attended the Annual Episodes Design Feedback Session meetings held on May 21, 2019. The meetings were an opportunity for stakeholders from across Tennessee to comment on what is working well and how to improve the clinical design of the 45 episodes of care that are in performance in 2019. The meetings were held simultaneously in six cities across Tennessee (Memphis, Jackson, Chattanooga, Nashville, Knoxville, and Johnson City) and connected via videoconference to make it easier for the public to participate. Members of the public were also able to submit their feedback electronically.

Based on the feedback received, the state is making 41 changes to the design of the episodes program for the 2020 performance period. These changes will first be reflected in the interim performance reports released in August 2020 that cover the first quarter of the 2020 performance period (January through March 2020).

The feedback is organized by episode in alphabetical order. The table "Summary of Program Changes Taking Effect in 2020" is also provided to highlight feedback that resulted in episode design changes for the 2020 performance year.

A Primer on the Episodes of Care Program

How are episodes designed?

Every episode is designed with recommendations from Tennessee clinicians, who form a Technical Advisory Group (TAG). These design recommendations include the episode trigger, the type of quarterback for the episode, included spend, episode duration, exclusions, risk factors, and quality metrics. For every episode that has been designed in Tennessee, clinicians' recommendations were incorporated into the episode design before implementation.

TAGs are composed of Tennessee clinicians with expertise in relevant specialties who volunteer their time to make recommendations on the clinical aspects of the episode design. Members are selected through a nomination process. TAGs meet in person multiple times as part of the episode design process.

How does the Episodes of Care program make fair comparisons across episodes?

The Episodes of Care program includes many components to make fair comparisons among providers. Risk adjustment is a method used to scale the episode spend up or down to account for patient

3

2019 and 2020 Episode Changes memo links can be found at https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care.html under Key Documents

THCII Episodes of Care

Have Questions?

Medicare Advantage

Quality Breakout Session

ALL Blue 2020

Medicare Advantage

Plan overviews

BlueAdvantage (PPO)SM

- Medicare Advantage plan for people who qualify for traditional Medicare
- More coverage than traditional Medicare (Parts A&B): dental, vision, hearing and prescription drug coverage
- Lower premiums than a Medicare Supplement
- Premiums as low as $0
- $0 Drug and medical deductibles
- Drug copays as low as $1
- Wide choice of doctors, hospitals, and dental and vision providers
- No referrals

BlueEssential (HMO SNP)SM

- Medicare Advantage Chronic Special Needs plan (C-SNP) for people who qualify for traditional Medicare who are living with diabetes
- Premiums as low as $0
- Lower member cost for certain medicines and equipment
- Improved coverage for diabetic care services
- Enhanced supplemental benefits
- Members must select a PCP

BlueCare Plus (HMO SNP)SM

- Dual Special Needs plan (D-SNP) for people who qualify for both traditional Medicare and Medicaid (TennCare)
- $0 Premiums
- $0 Drug and medical deductibles
- Routine dental, vision and hearing coverage
- No referrals
- Prescription coverage
- Transportation services

BlueCare Plus Choice (HMO SNP)SM

- Fully Integrated Dual Eligible (FIDE) plan for people who qualify for both traditional Medicare and Medicaid (TennCare)
- $0 Premiums
- $0 Drug and medical deductibles
- No referrals
- Covers all of the core benefits under original Medicare and all supplemental benefits included with BlueCare Plus
- Any Medicaid-only benefits under TennCare are also included

2020 Quality Amendment Measures

BlueAdvantage and BlueEssential

2020 Calendar Year

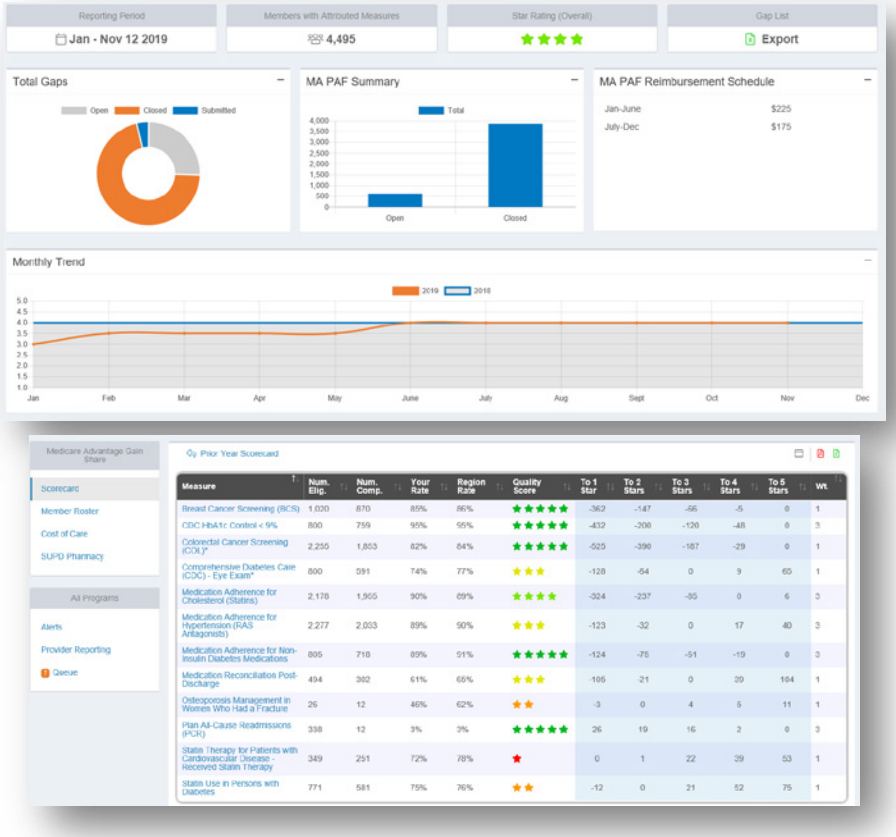
Medicare Advantage Quality Amendment Measures

Measure Name	Measure Type	Weight	Member Incentive Available
Comprehensive Diabetes Care (CDC) – HbA1c Control (≤8.9%)	Outcome	3	$25
Medication Adherence for Cholesterol (Statins)	Outcome	3	---
Medication Adherence for Hypertension (RASA)	Outcome	3	---
Medication Adherence for Diabetes Medications (OAD)	Outcome	3	---
Plan All-Cause Readmissions (PCR)	Outcome	3	---
Breast Cancer Screening (BCS)	Procedure	1	$50
Colorectal Cancer Screening (COL)	Procedure	1	$20 - $75
Comprehensive Diabetes Care (CDC) – Retinal Eye Exam	Procedure	1	$50
Comprehensive Diabetes Care (CDC) – Medical Attention for Nephropathy	Procedure	1	$15
Controlling Blood Pressure (CBP)	Outcome	1	---
Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	Procedure	1	---
Medication Reconciliation Post Discharge (MRP)	Procedure	1	---
Osteoporosis Management in Women with a Fracture (OMW)	Procedure	1	---
Statin Therapy for Patients with Cardiovascular Disease (SPC)	Procedure	1	---
Statin Use in Persons with Diabetes (SUPD)	Outcome	1	---
Measures for Display/Monitoring Status Only			
Health Outcomes Survey: Bladder Control	HOS Survey	0	---
Health Outcomes Survey: Monitoring Physical Activity	HOS Survey	0	---
Health Outcomes Survey: Reducing the Risk of Falls	HOS Survey	0	---
Annual Wellness Visit (AWV)	Procedure	0	$30
Use of Multiple Anticholinergic (ACH) Medications in Older Adults (Poly-ACH)	Outcome	0	---
Use of Multiple Central-Nervous System (CNS)-Active Medications in Older Adults (Poly-CNS)	Outcome	0	---
Medicare Diabetes Prevention Program Participation for 6 Months	---	0	---

Quality Care Rewards (QCR) Tool

All plans

The **Quality Care Rewards (QCR)** tool in Availity® allows you to access the **Quality+ Partnerships** programs that apply to your practice. There you can identify gaps in care for your patients, attest to completed screenings, fill out and upload annual provider assessment forms, review your practice's overall progress on quality measures and STARS score, and much more.



For assistance or more information about Availity and the Quality Care Rewards tool, please contact our eBusiness Technical Support Team:

Phone: (423) 535-5717, Option 2
Email: eBusiness_service@bcbst.com

Note: QCR system refresh occurs each Thursday afternoon and includes attestation, CDE and claims data through the end of the week approximately two weeks prior.

Provider Assessment Forms (PAF)

BlueAdvantage and BlueEssential

The Provider Assessment Form (PAF) is an important tool for collecting comprehensive details on each patient's current health status annually. It shows how all active and chronic conditions are documented and managed. The PAF data may also close some quality measure gaps.

2020 Tiered Incentive Schedule

- $225 – January through June
- $175 – July through December

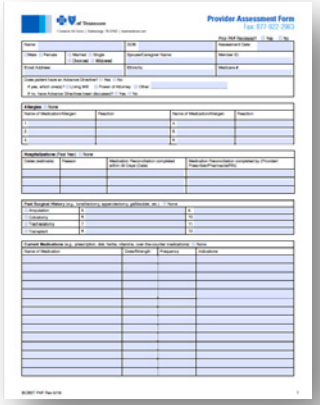
Important details

- Complete during a patient's **face-to-face visit.**
- Submit via online, upload to QCR or fax **within 30 days** of visit.
- Submit claim with **CPT® code 96160** once per calendar year with your visit E/M code **within six months** of visit.
- Incentive payment is based on date of service.
- May only be submitted **once per calendar year**, but you don't have to wait 365 days between visits.
- You are encouraged to perform the Medicare Annual Wellness Visit at the same time.
- Members also get incentives for completing their Annual Wellness Visit.

For more information on Provider Assessment Forms (PAFs), please see the PAF pages in the Provider Guide

Completion options

- Online via Availity in the QCR tool.
- Upload to the QCR tool or fax your BlueCross-approved non-standard PAF from your medical records to 1-877-922-2963.
- Access the writeable PDF at the Quality Care Rewards website and upload to the QCR tool or fax the completed form to 1-877-922-2963.
  - The PAF is available at bcbst.com in the provider section.



My Healthpath® Member Wellness and Rewards

BlueAdvantage and BlueEssential

Available Member Incentives for 2020

Measure / Activity	Gift Card Amount	Incentive Criteria
Annual Wellness Visit (AWV)	$30	Available for all members annually who complete an Annual Wellness Visit
Breast Cancer Screening (BCS)	$50	Available for Women ages 52-74 every other year who complete a mammogram at a provider facility
Colorectal Cancer Screening (COL)	$20	Available for members ages 51-75 annually who complete a gFOBT/iFOBT. Incentive only available in absence of FIT-DNA in the previous three years, sigmoidoscopy or CT Colonography within the previous 5 years or colonoscopy within the previous 10 years
	$30	Available for members ages 51-75 every three years and for members that complete a FIT-DNA (Cologuard®)
	$50	Available for members ages 51-75 every 5 years who complete a CT Colonography or Sigmoidoscopy at a provider facility
	$75	Available for members ages 51-75 every 10 years who complete a Colonoscopy at a provider facility
Comprehensive Diabetes Care (CDC) - A1C Control (≤8.9%)	$25	Available for diabetic members ages 18-75 annually who complete an A1C test at home, in the provider office or at a BlueCross community outreach event
Comprehensive Diabetes Care (CDC) – Retinal Eye Exam	$50	Available for diabetic members ages 18-75 annually who complete a retinal eye exam at an ophthalmologist or optometrist provider office, in-home, in the provider office or at a BlueCross community outreach event
Comprehensive Diabetes Care (CDC) – Medical Attention for Nephropathy	$15	Available for diabetic members ages 18-75 annually who complete a urine nephropathy screening test in home or in the provider office
Health Needs Assessment (HNA)	$20	Available for all members who complete a health needs assessment online, by phone or mail

Members must opt-in to the program to earn gift cards. Incentives only available for tests and screenings that the member needs and for which an open HEDIS gap in care exists.

In-Office Health Screening Events

All plans

Preventive care helps your patients improve their ability to lead healthy lives.

We're here to help support you with flexible in-office screening events.

Services we provide can include:

- Breast Cancer Screening*
- Colorectal Cancer Screening**
- Diabetic Retinal Eye Exam
- HbA1c Blood Test***
- Diabetic Kidney Disease Screening***

Completed by BlueCross vendor partners and/or your office

We prefer to prioritize patients who haven't yet received these screenings during this calendar year for in-office events. If your patient completes a test that's included in the Medicare Advantage Quality+ Partnerships program, you'll get credit from us and your patient may earn gift cards if they're enrolled in the My HealthPath® rewards program.

*Block-scheduling availability or mobile van as available
**In-Office, In-Home or block-scheduling availability
***In-Office or In-Home Kit

You Make a Big Difference in Your Patient's Experience

All plans

The Consumer Assessment of Healthcare Providers and Systems (CAHPSR) and the Medicare Health Outcomes Survey (HOS) annual surveys are used by CMS to evaluate care and services provided to your patients. Your patients are asked to respond to survey questions in several categories. We've included a few HOS measures below with tips on how you can help improve patient satisfaction.

Reducing the Risk of Falling

- Discuss balance problems, falls, difficulty walking and other risk factors for falls.
- Recommend the use of a walker or cane, if appropriate.
- Check standing, sitting and reclining blood pressures.
- Recommend a physical therapy or exercise program, if appropriate.
- Recommend vision and hearing tests, if appropriate.
- Perform bone density screenings, especially for patients at risk.
- Consider a home safety assessment to look for risks for tripping.

Improving or Maintaining Physical Health

- Assess patients' physical health, functional status and activity.
- Talk to your patients about their level of physical activity and encourage them to start, maintain or increase activity, if appropriate.
- Assess pain and intervene, if appropriate.
- Encourage members to use their free Silver&Fit® gym membership benefit.

Improving Bladder Control

- Screen all patients for urinary incontinence and discuss treatment options if positive.
- Recommend treatment options no matter the frequency or severity of the bladder control problem.

For more information on specific HOS questions asked of your patients, see our Member Survey Experience page in the Provider Guide

Best Practice Tips

All plans

Sample Best Practice Tips

Provider Assessment Form (PAF) Completion

- Begin scheduling Annual Wellness Visits in late December for the following year or early January. The benefits of completing the PAF during the Annual Wellness Visit will allow the creation of a member-centric preventive care plan to be worked on through the year.
- Review your list of BlueAdvantage patients on at least a quarterly basis to identify those that still need a PAF.
- Encourage office staff to see if a PAF has been completed when patients call to schedule return office visits.

Medication Reconciliation Post-Discharge/Transitions of Care

- Partner with local hospitals to make sure you're receiving discharge information for patients.
- Use on-hold messaging opportunities to remind your patients to schedule a follow-up visit within five days of being discharged.
- Follow the guidelines for Transitional Care Management after a discharge to close the Medication Reconciliation Post-Discharge gap and also receive higher reimbursement than a traditional office visit.

Breast Cancer Screening

- Remind patients that if they participate in the member incentive program, they can receive a gift card for getting their mammogram: "Did you know you can receive a $50 gift card for having a mammogram?"
- Partner with the imaging center in your community and host a day or evening event for your patients. Let us know how we can help.
- Use lobby video streaming services to highlight the importance of mammograms throughout the year.

Colorectal Cancer Screening

- Inform patients that screening can decrease or prevent colorectal cancer-related mortality.
- Discuss patients' fears and concerns about having a colorectal cancer screening.
- Offer patients different prep options and encourage a low-residue diet the week before the procedure.

Osteoporosis Management in Women with a Fracture

- Schedule bone density screening in conjunction with a mammogram every two years.

Diabetic Eye Exams

- Consider purchasing a mobile retinal scanner so you can complete eye exams on your patients who don't routinely see an eye care professional.

For more helpful tips, see our Best Practices pages in the back of the Provider Guide

We're Right Here

For more information about the Medicare Advantage Quality Program or Resources, please contact our Provider Engagement and Outreach Team

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Ashley_Ward@bcbst.com

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Medicare Advantage

Have Questions?

Provider Dispute Resolution Procedure

Claims Reconsiderations and Appeals

ALL Blue 2020

Provider Dispute Resolution Procedure

Claims reconsiderations and appeals

Purpose: To address and resolve any and all matters causing participating providers ("Providers") or BlueCross BlueShield of Tennessee or its affiliated companies ("BlueCross") to be dissatisfied with any aspect of their relationship with the other party (a "Dispute").

Providers are encouraged to contact a representative of the BlueCross Provider Network Management Division if they have any questions about this procedure statement or concerns related to their network participation.

Applies to: All BlueCross Commercial contracts; Individual and Group contracts including but not limited to State of TN Employees, Federal Employee Program (FEP), BlueCard (providers not in TN or bordering counties should contact their Local BlueCross BlueShield Plan).

BlueCare Tennessee, TennCare*Select,* CoverKids

BlueCare Plus (HMO SNP)SM

Medicare Advantage - BlueAdvantage (PPO)SM and BlueEssential (HMO SNP)SM

Provider Dispute Resolution Procedure

Claims reconsiderations and appeals

Common Terms

Claim Reconsideration – allows providers who are dissatisfied with a claims outcome or denial to request an additional review. Also referred to as Level I.

Appeal – allows providers who are dissatisfied with a claim reconsideration outcome or denial to formally dispute the decision in writing and provide BCBST additional documentation. Also referred to as Level II.

Arbitration – allows providers who are dissatisfied with a claims reconsideration and appeals process outcomes to see resolution by a third party.

Authorization-related reconsiderations or re-evaluations – these reconsiderations/re-evaluations occur before or during services being rendered but before billing occurs. Also referred to as Medical Management or Utilization Management.

Provider Dispute Resolution Procedure

Claims reconsiderations and appeals

Common Terms

Non-compliant – when prior authorization is required, an authorization must be obtained by the provider(s) before scheduled services and within two business days for emergent services. Failure to comply within specified authorization timeframes will result in a denial or reduced benefits for non-compliance; BlueCross participating providers are prohibited from billing members for covered services rendered, with the exception of applicable copayment/deductible and coinsurance amounts. Claims denials for non-compliance are subject to a Claims Appeal only.

Timeliness – the amount of time allowed to pursue reconsideration or to appeal an upheld decision or denial for a claims reconsideration or appeal.

Provider Dispute Resolution Procedure

Claims reconsiderations and appeals

What is a Provider Claim Reconsideration?

- A claim reconsideration allows providers dissatisfied with a claims outcome or denial to request an additional review. Reconsiderations must be completed before filing a formal appeal, with the exception of claims appeals of non-compliant denials.
  - Must be submitted within 18-months of the adverse determination (i.e. remittance advice).
  - May be initiated by calling BlueCross or using the Provider Reconsideration Form.
  - Adequate supporting documentation may be provided for adjudicated claims to be reconsidered.
  - Providers who are not satisfied with the outcome of the reconsideration may file a formal Provider Appeal.
- Provider claim reconsiderations may be requested in reference to numerous topics including but not limited to the following:
  - Corrected claims
  - Coordination of benefits
  - Diagnosis codes
  - Procedure or revenue codes
  - Recoupment disputes

Provider Dispute Resolution Procedure

Claims reconsiderations and appeals

What is a Provider Claim Appeal?

- An appeal allows providers dissatisfied with a claim reconsideration determination to formally dispute the denial in writing and provide additional documentation to BlueCross.
  - Must be submitted in writing using the Provider Appeal Form.
  - Must be submitted within 60 days of reconsideration determination notification.
  - Only one appeal is allowed per claim, patient or issue per form.
  - For adjudicated claims, adequate supporting documentation must be provided.
- NOTE: If the reconsideration process identified the decision was related to medical necessity, you may be directed to a separate Utilization Management appeal form.
- Providers who are dissatisfied with a claims appeal determination may pursue the dispute further through binding arbitration. Refer to the Provider Dispute Resolution Procedure II.C, published in the BlueCross Commercial and BlueCare Provider Administration Manuals.

Provider Dispute Resolution Procedure

Claims reconsiderations and appeals

Key Points to Remember

- Utilization management authorization appeals are handled by a medical team.
- Each line of business has dedicated UM appeal fax numbers.
- Claims appeals are handled by an administrative team.
- After the authorization appeals process is complete, you may not begin the claims appeal process. The next step is arbitration.
- Providers cover the costs associated with arbitration and independent reviews.
- The Provider Dispute Resolution process allows for one reconsideration, followed by one appeal per claim issue.
- Duplicate requests or improperly submitted forms will be returned without additional review.

Provider Dispute Resolution Procedure

Have Questions?

BlueCare Tennessee

BlueCare

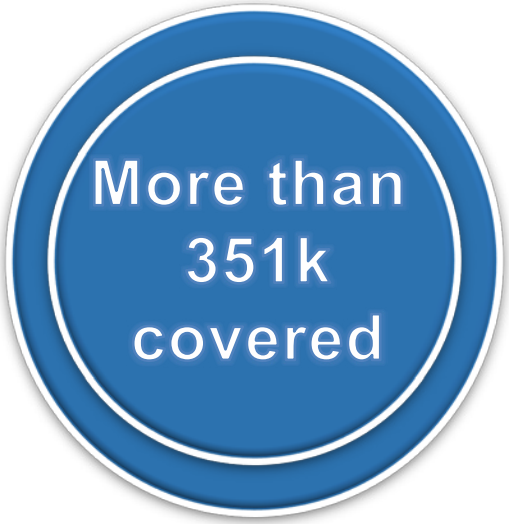
TennCare Kids – EPSDT

ALL Blue 2020

BlueCare

TennCare Kids – membership and goals

BlueCare Tennessee provides health plans to more than 355,000 members under the age of 21.



- Our goal is to ensure each child receives appropriate health care.
- This can be accomplished with your help through their TennCare Kids checkups.

These services should be performed based on Bright Futures/American Academy of Pediatrics – “Recommendations for Preventive Pediatric Health Care”

BlueCare

TennCare Kids – we need your help

We Need Your Help			
Schedule appointments and provide reminders for patients.	Document all components of the exam in the patient's medical record.	Bill appropriately to maximize your reimbursement.	Convert sports physicals to Well-Care visits.
Pre-schedule newborn checkups.	Alternate and extended office hours.	Combine a Well-Care visit with other types of visits.	Assign staff specifically to handle Well-Care visits.

BlueCare

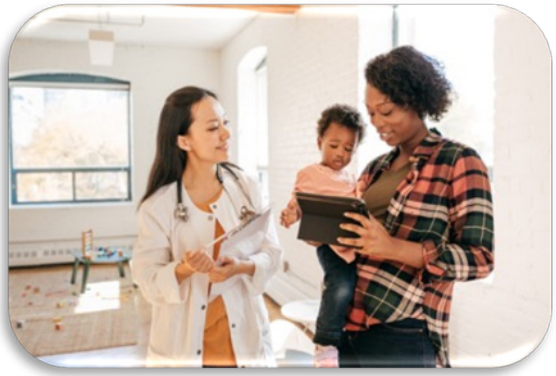
TennCare Kids – documenting care

Medical record documentation is very important

- Document all seven TennCare Kids exam components.
- This includes refusals and uncooperative patients (document vaccine refusals with the AAP's Refusal to Vaccinate form at TNAAP.org).

TennCare Kids exam components :

- Comprehensive heath and developmental history
- Comprehensive unclothed physical exam
- Vision screening
- Hearing screening
- Laboratory tests/procedures
- Immunizations
- Health education/anticipatory guidance



BlueCare

Commonly missing documentation elements

- Immunization status
- Screening for sexually transmitted diseases
- Hemoglobin or hematocrit levels
- Lead assessments and blood lead testing, when applicable
- Nutritional counseling
- Developmental assessments
- Height/weight growth parameters
- Documentation of anticipatory guidance
- Dental referrals
- Documentation of the periodicity appointment
- Return appointment for next scheduled EPSDT visit
- Documentation for the additional evaluation and management visit that's reimbursed (example: using modifier 25)
- Documentation that an unclothed exam was performed

BlueCare

Commonly missing documentation elements

Exam Refusals

- Include detailed documentation in the medical record.
- Patient is a minor and accompanied by their guardian, document that the guardian refused care and the reason.
- Document attempt to educate the patient's guardian.
- Document additional attempts to schedule exams after an exam refusal.

Credit for Well–Visit Performed

- Screening rates are calculated from your claims.
- Make sure to bill accurately and completely.
- Submit claims for children with two insurance providers.

Appointment Cancellations

- Investigate your EHR's capabilities — most can help manage and schedule patient visits.

BlueCare

BlueCare Resources - Quality Care Rewards

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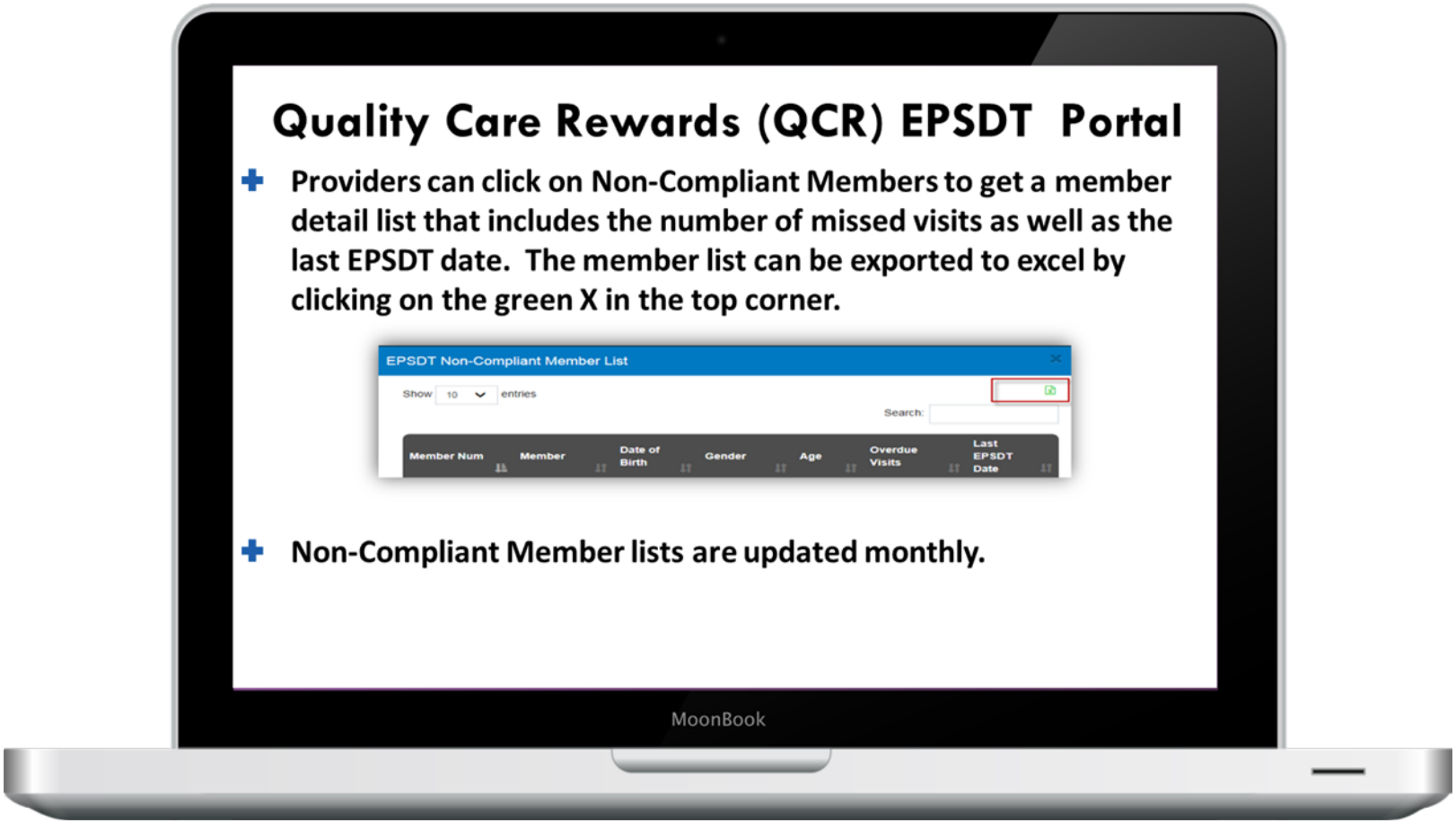
BlueCare Resources - Quality Care Rewards



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BlueCare

BlueCare Resources - EPSDT Partners in Prevention Toolkit

- Created to make it easier for providers to find important information in serving their patients who are BlueCare Tennessee members. Toolkit includes:
  - American Academy of Pediatrics periodicity chart and coding information
  - Contact phone numbers for a wide range of services for providers and their patients
  - Best practices shared by providers from across the state
  - Details about free transportation for their patients
  - Community outreach opportunities
  - Inside look at our claims process and much more

The Toolkit be found online at:
bluecare.bcbst.com/providers/tools-resources/general/tenncare-kids-toolkit.html

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BlueCare EPSDT

Have Questions?

Behavioral Health

Ongoing Initiatives and Innovations

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Continued Focus on Integrating Medical and Behavioral Health

Understanding the value of caring for the whole person

- According to the National Institute of Mental Health, 51% of adults with bipolar disorder and 40% of adults with schizophrenia did not get treatment over the course of a one-year study.
- Not getting the right kind of care also has major financial implications, with the National Alliance on Mental Health estimating that untreated mental illness costs the US up to $300 billion annually.
- BH has focused on an integrated approach since inception, meeting members where they are in their health journey.
- We have also seen improvements in care as Patient Centered Medical Homes (PCMH) embed BH staff in their practices.
- We have also discussed mental health conditions and how conditions such as diabetes and depression can be connected at PCMH conferences.

Taking Care of Our Members

Striving to provide quality health care to our members as measured through HEDIS® quality metrics

- Ensure flexibility when scheduling appointments for patients who are being discharged from acute care; the appointment should be scheduled within seven days of discharge. Visits on the day of discharge do not count toward this metric.
- Schedule a follow-up appointment as soon as you get notification of the ED visit.
- When a substance use concern is identified, it's very important to schedule appropriate follow-up treatment. For newly diagnosed patients, in particular, it is recommended that you schedule the initial appointment within 14 days and a follow-up appointment within the first 34 days.
- Prescribe antipsychotic medication after the patient has tried therapy (within 90 days of documented psychosocial care).

Medication Assisted Therapy (MAT) Coaching

The role of the MAT Quality Coach

- Meet with all providers entering the network for initial education
- Annual audit
- Quality metrics
- Quality improvement coaching
- Annual education

Medication Assisted Therapy (MAT) Coaching

BMAT Program Description

- **Each provider attests to adherence to the BMAT program description in the credentialing process**
- **The program description includes standards related to the following:**
  - Program structure (policy and procedure)
  - Adequate patient assessment and evaluation prior to initiation of MAT
  - Using buprenorphine/naloxone combination unless contraindicated
  - Prescribed minimum frequencies of office visits
  - Prescribed minimum frequencies of counseling services
  - Regular and random observed drug screening
  - Care coordination
  - Peer recovery
  - Adequate diversion control
  - Harm reduction training for patients (contraception, prevention of viral illnesses, overdose risk and prevention, etc.)

Medication Assisted Therapy (MAT) Coaching

BMAT audit process and quality metrics

- **Audit Process**
  - Annual on-site audit will be conducted by Quality Coach
  - Audit is based on Program Description
  - Your Policy and Procedure as well as 10 BlueCare member records will be reviewed
  - First annual audit is educational
  - Second annual audit and those thereafter will require a corrective action
  - plan for any items scoring below 80%
  - Quality Coach will work with you to provide guidance and feedback to improve audit performance
- **Quality Metrics**
  - Metrics are based on claims and Quality Coach can provide guidance on opportunities for improvement
  - Days of Continuous MAT
  - Relapse Rate
  - Concomitant Benzodiazepine or Opioid Use
  - Urine Drug Screen frequency rate
  - Behavioral Health Visit rate

Project ECHO

Current outreach efforts

- **12 ECHO sessions providing training on Opioid Use Disorder (OUD) were held between July 31, 2019 – Oct. 16, 2019**
  - Each session had an average of five attendees.
  - 12 unique provider groups/practices registered and/or attended.
  - Sessions were led by presenters that clearly communicated and gave providers the opportunity to ask questions.
  - Over half of providers surveyed after the sessions found them to be educational and served as a refresher.
  - Providers who participated in the survey commented they would incorporate what they learned in their practice.

Behavioral Health

Have Questions?