FALL 2019

AFC CONNECT

HMO Provider Newsletter

2019 and 2020 CMS HCC Model Update

ENHANCING PATIENT-DOCTOR COMMUNICATION

GUN INCIDENTS IN THE MEDICAL OFFICE

SILENCE is NOT AN OPTION

Your Quality SCORES "MRR Scores"

AND much more!

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2019 AND 2020 CMS HCC Model Updates

Medicare Risk Adjustment has been full of significant changes recently including revamping of the Hierarchical Condition Categories (HCCs) Models. The CMS 2019 and 2020 payment years (PY) HCC Models include mandatory changes due to the 21st Century Cures Act. You will find new HCCs as well as updated risk score coefficients.

The Payment Year 2019 HCC Model (effective 2018 dates of service) includes changes to Drug Abuse and Drug/Alcohol Dependence, Mental Health and Chronic Kidney Disease. You will find an expanded code set for Drug/Alcohol Dependence under HCC 55. In addition, a new category has been created for Uncomplicated Drug Abuse, HCC 56. Mental Health categories have been enhanced with two new HCCs titled Reactive and Unspecific Psychosis, HCC 58, and Personality Disorders, HCC 60. You will find the previous category titled Major Depressive, Bipolar, and Paranoid Disorders has been relabeled to HCC 59. Chronic Kidney Disease Stage 3 has also made a comeback for risk adjustment purposes with its own newly created HCC 138.

The Payment Year 2020 HCC Model (effective 2019 dates of service) also includes exciting changes involving Dementia and Pressure Ulcers. Two new HCCs have been created for Dementia with Complications, HCC 51, and Dementia without Complication, HCC 52. Ulcers have gained a new category for Pressure Ulcer of Skin with Partial Thickness Skin Loss, HCC 159.

It is now more important than ever that providers diagnose and accurately document these diseases to the highest degree of specificity so the most specific diagnosis code can be selected. Often, specificity in documentation is the difference between a diagnosis code that risk adjusts or not. Detailed documentation is required to support each HCC and is the driving force behind successful risk adjustment practices.

Socioeconomic Status and Diabetic Care

The Health Plan has invested additional resources into the care of its members that may be at risk for developing diabetes. The Chronic Care Improvement Project (CCIP) is a three-year commitment made by the Health Plan to identify those members with an at risk HgbA1c level.

When considering your treatment plan please consider the cost of medications as many patients are on a fixed income and may have difficulty affording medications or services. Asking the patient if they will be able to afford their medications is a simple, and direct, approach to determining if the patient will follow your treatment plan.

If a patient voices concern regarding their ability to afford their medications, you can refer them back to the Health Plan for assistance. The Health Plan has a staff of highly skilled social workers who can help identify financial resources that may be able to reduce or eliminate patient co-pays. The service is included with their benefit package.

ENHANCING PATIENT-DOCTOR **COMMUNICATION**

One of the essential factors in achieving patient-centered care is good physician-patient communication, this is one element that should not be overlooked. There are many suggestions such as maintaining eye contact as well as talking slowly, clearly and less often. You can also use the Teach-Back and Ask Me 3 Methods. The Teach-Back method is when you ask the patient to explain in their own words the information you gave them. This method demonstrates understanding and comprehension of the information the patient received. It also lets the patient take an active role in their care and lets the physician assess health literacy and understanding which ultimately helps improve health outcomes.

The Ask Me 3 Method encourages patients to ask 3 questions:

1.) What is my main problem?

2.) What do I need to do?

3.) Why is it important for me to do this?

While it may not be customary, you can improve patient-physician communication by sharing your patient's medical notes with them. When patients can read their medical notes, it fosters patient engagement. Ultimately, when patients are more actively involved in their care, it enhances their care experiences, builds trust between the physician and patient, and improves their satisfaction.

Also, if a patient can read what is on the chart, he or she will have the opportunity to correct any mistakes or add other helpful details, thereby preventing medical errors. Notes-sharing also counts towards the Meaningful Use Stage 1 requirement of providing patients with an electronic copy of their health information, and the Stage 2 requirement of providing clinical summaries for patients for each office visit.

While there are many platforms for sharing notes with patients, such as the OpenNotes project, physicians don't need to implement a formal electronic program to join this movement towards transparency and patient engagement. Physicians can start engaging their patients today just by letting them look at their records during their regular appointments. It's a simple gesture with surprisingly beneficial results.

Guns are pervasive and threats of gun violence are a reality. As a medical provider, one of your foremost duties is patient and staff safety. An effective office safety program involves identifying hazards, developing a plan to mitigate them and having practice drills, thereby protecting people and premises. Certain factors may act as catalysts for gun incidents in medical offices:

- an anxious or angry patient or family member;
- long wait times, especially as the day progresses;
- patients/family left in waiting or exam rooms with no information or attention from staff;
- provider use of cell phones or computers, giving the impression of unconcern.

PLAN

- recognize that an incident might occur; formulate a plan for dealing with it.
- review your plan with staff. Train staff to recognize signs of patient or family stress, including nonverbal language – and to defuse the situation with simple strategies: calming talk, a bottle of water or a separate waiting area.
- evaluate the physical setup of the office and make changes if needed.
- Keep doors between waiting and exam areas locked, including the back door.
- Secure the reception area with a glass or heavy-duty plastic partition.
- Install cameras in waiting rooms and hallways.
- Give the front-desk person a code or alarm with which to alert others, and a list of emergency numbers.
- ask a police officer to speak to staff about office security and de-escalation tactics.
- call the police before a situation turns violent.
- post signs in the office that violence of any kind will not be tolerated and will be reported to the police.

PRACTICE

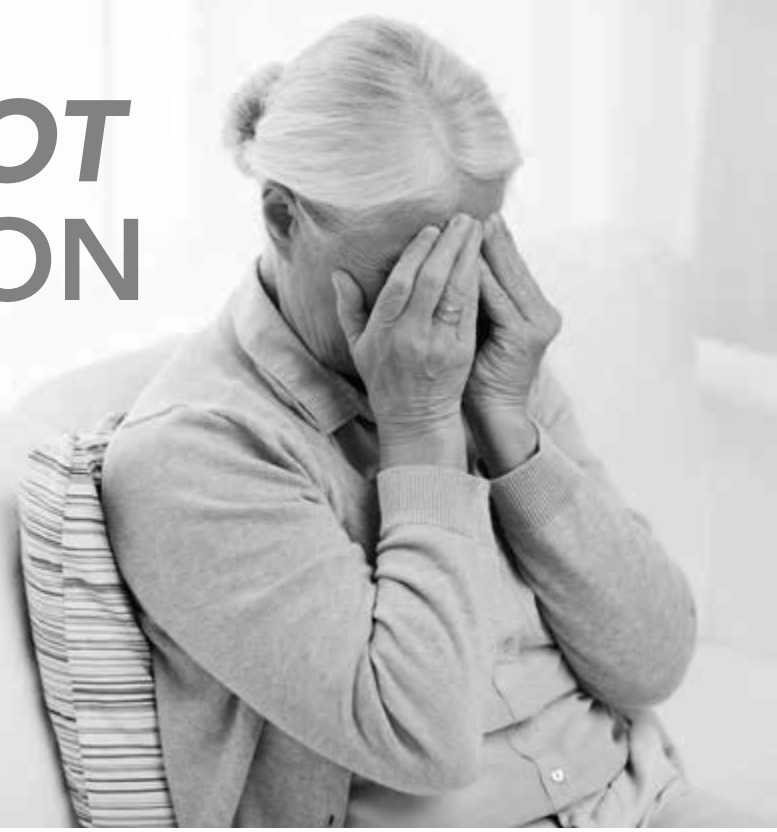
- hold safety drills according to your written plan; change the plan as needed.
- keep a record of your drills.

For more tips and guidelines, see OSHA's "Preventing Workplace Violence in Healthcare:"

osha.gov/dsg/hospitals/workplace_violence.html

SILENCE IS *NOT* AN OPTION

ABUSE, NEGLECT & EXPLOITATION



Elder abuse, neglect or exploitation does not usually end on its own - someone must report it! A victim may not reach out for help for various reasons such as shame or fear. As a mandatory reporter, you can take the first step to end the abuse.

WHO IS A MANDATORY REPORTER?

Health care providers, including nurses, are mandatory reporters of abuse, neglect or exploitation of the elderly, children and vulnerable adults. According to S. Carolina Code of Laws, Title 43, a vulnerable adult is a person eighteen years of age or older who has a physical or mental condition which substantially impairs the person from adequately providing for his or her own care or protection. This includes a person who is impaired in the ability to adequately provide for the person's own care or protection because of the infirmities of aging including, but not limited to, organic brain damage, advanced age, and physical, mental, or emotional dysfunction.

WILL THERE BE ANY CONSEQUENCES?

According to S. Carolina Statute Adult Protection, Article 1, Section 43-35-85, "A person required to report under this chapter who knowingly and willfully fails to report abuse, neglect, or exploitation is guilty of a misdemeanor and, upon conviction, must be fined not more than twenty-five hundred dollars or imprisoned not more than one year.

WHAT DOES IT LOOK LIKE?

Abuse or neglect is not always easy to spot but there are signs to look out for:

- Trouble Sleeping
- Seems depressed, confused, agitated, violent or withdrawn
- Unexplained bruises, scars or accidents
- Develops sores or other preventable conditions
- Makes concerning statements about caregiver withholding money or medication
- Loses weight for no reason

HOW DO I MAKE A REPORT?

please visit
HTTPS://DSS.SC.GOV/CONTACT/

CONTACT THE COUNTY DSS OFFICE OR CONTACT LOCAL LAW ENFORCEMENT WHERE THE PERSON RESIDES TO REPORT ABUSE, NEGLECT OR EXPLOITATION

Remember, an investigator wants to speak with the person who observed the abuse, neglect or exploitation firsthand.

If you suspect it, report it!

QUALITY MANAGEMENT
THE RESULTS ARE IN!

Our goal at America's 1st Choice (SC HMO) is to help our members improve their health by providing the best care and service options. In order to do this, we rely on our Quality Management (QM) program. The QM program monitors the quality of care given by Plan providers. The QM Program also looks for areas of service that need to be improved.

Every year, we measure to see the progress we have made toward meeting our goals for healthy members. One of the tools we use to do this is called HEDIS®, which stands for **H**ealthcare **E**ffectiveness **D**ata and **I**nformation **S**et. HEDIS® is a very common tool used by health care plans to see how well they are serving their members. We use these HEDIS® results to see where we need to focus our improvement efforts.

For more information on HEDIS® and Quality Measurement, go to
http://www.ncqa.org/HEDISQualityMeasurement.aspx

You can also call Member Services at
1-888-563-3289.

Our 2019 HEDIS® results show that America's 1st Choice (SC HMO) ***met or improved our quality goals*** in many HEDIS® measures. These areas include:

- Adult Access to Preventive Services
- Adult BMI Assessment
- CDC: Good HbA1c Control (< 8), HbA1c Testing and Diabetic Nephropathy
- Use of High Risk medications in the Elderly - one script
- Pharmacotherapy Management of COPD-Systemic Corticosteroid
- Spirometry Testing

Areas where we ***would like to improve our performance*** include:

- Breast Cancer Screening
- Controlling High Blood Pressure
- CDC: Poor HbA1c Control (> 9), BP Controlled < 140/90 and Eye Exams
- Colorectal Cancer Screening
- Use of High Risk Medications in the Elderly - two scripts
- Medication Reconciliation Post- Discharge
- Pharmacotherapy Management of COPD-Bronchodilator
- SUPD: Statin Use in Diabetics

PCE: Pharmacotherapy Management of COPD Exacerbation

The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1–November 30 of the measurement year and who were dispensed appropriate medications.

Two rates are reported:

1. **Corticosteroid**
   The member is dispensed a systemic corticosteroid (or there was evidence of an active prescription)
2. **Bronchodilator**
   The member is dispensed a bronchodilator (or there was evidence of an active prescription)

These two rates should be completed every time a member has a qualifying COPD exacerbation event. A member can be part of the eligible population multiple times during the measurement year as the eligible population is based on acute inpatient discharges and ED visits. It is possible for the denominator to include multiple events for the same individual.

A comprehensive list of medications and NDC codes that qualify for this measure are available at www.ncqa.org

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

The IET HEDIS® Measure aims to quantify the percentage of adolescent and adult members who received treatment after a new episode of alcohol or other drug abuse or dependence (AOD).

Requirements:

Progress notes documenting initiation of AOD treatment within 14 days of diagnosis, and two or more additional services within **34** days of the initiation visit.

The following time sensitive steps are required to meet measure compliance:

- Initiation of AOD treatment (a CMS Star Score measure) through an inpatient AOD admission, outpatient visit (including office visit), intensive outpatient encounter or partial hospitalization, **telehealth or medication treatment** within 14 days of diagnosis.
- Engagement of AOD treatment for those who had two or more additional services with a diagnosis of AOD within **34** days of the initiation visit.

Let's work together to continue our improvement of HEDIS® scores and our overall quality of care. Our goal is to deliver excellence in all of our health care services!

Find a full list of the Plan's HEDIS® results online at:

https://sch.americas1stchoice.com → About Us → Utilization & Quality → Quality Management → Monitoring Quality

Your Quality SCORES

Medical Record Standards

Our Plan's goal for medical record documentation compliance is to consistently excel across the ten (10) components noted below. The Plan's Quality Management department uses these standards to conduct annual audits of sampled medical records and score network provider performance.

Those components are

- The record is legible
- Past medical history
- History and physical
- Allergies and adverse reactions
- Problem list
- Medication list
- Working diagnoses and treatment plans
- Unresolved problems
- Documentation of clinical findings and evaluation
- Preventive services and/or risk screening

We require that providers maintain the utmost quality of medical record documentation and ask that you pay special attention to these ten standards in your future record-keeping practices. We are very proud of our providers. Almost all ten (10) of the medical record standard components met the goal of 90 percent or greater compliance.

If you have any further questions, please contact your Provider Relations Representative. For additional medical record criteria and documentation standards/ requirements for adherence, please refer to our Provider Manual. Download a copy from our website:

https://sch.americas1stchoice.com/dlsecure/?_id=5013282

To request a paper copy of the Provider Manual, please contact your Provider Relations representative.

2019 MRR Standard Component CY2018 AFC	Frequency of Total Survey	
Is the record legible?	100.0%	Of those medical records reviewed, almost all met the goal of 90 percent or greater compliance. The three (3) individual components that scored lower than 90 percent were "Are allergies & adverse reactions to medications prominently displayed?" "Is there a completed problem list?" and "Is there a medication list?" in which the frequency of the total survey was 80.5, 73.2, and 88.4 percent, respectively.
Is there an appropriate past medical history in the record?	93.9%	
Is the history and physical documented?	99.4%	
Are allergies and adverse reactions to medications prominently displayed?	80.5%	
Is there a completed problem list?	73.2%	
Is there a medication list?	88.4%	
Is there a working diagnosis(es) and treatment plan(s)?	97.0%	
Are unresolved problems documented?	89.6%	
Is there documentation of clinical findings and evaluation?	100.0%	
Is there documentation of preventive services and/or risk screening?	96.3%	

Follow-Up after Hospitalization for Mental Illness (FUH)

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had any one of the following with a mental health practitioner.

- Outpatient visit
- An intensive outpatient encounter or partial hospitalization
- A community mental health center visit
- Electroconvulsive therapy
- Observation visit

Two rates are reported:

- The percentage of discharges for which the member received follow-up within 30 days after discharge.

- The percentage of discharges for which the member received follow-up within 7 days after discharge.

The following time sensitive steps are required to meet measure compliance:

30-Day Follow-Up: A follow-up visit with a mental health practitioner within 30 days after discharge.

7-Day Follow-Up: A follow-up visit with a mental health practitioner within 7 days after discharge.

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CREDENTIALING CORNER

The plan accepts CAQH Proview Credentialing applications.

When logging into the CAQH ProView Provider System to update or re-attest to your information, please review the informational banners used by CAQH to announce system updates and be sure to review the monthly ProView updates CAQH sends out via email.

Also, please continue to keep your credentialing application and attached documentation current in the CAQH Proview database. The following items are of much importance in the credentialing process:

- **State Medical License(s) please include expiration date(s)**
- **DEA Certificate**
- **Valid Insurance Information**
- **Practice locations**
- **Hospital Admitting privileges OR if you are a PCP and you do not have hospital admitting privileges please ensure the Hospital Admitting Arrangements Supplemental Form is fully completed**
- **Partners/Covering Colleagues**
- **Questionnaire responses and explanations as required.**

Thank you for your timely submission!

.....and one more quick reminder, please promptly notify us of any change in your location or other credential, or if you are adding a new practitioner to your practice.

For Providers Not Part of CAQH Proview:

The plan sends notification and re-credentialing applications by mail four months in advance of a providers credentialing expiration date. The notification cover letter specifies the steps and documents needed for re-credentialing, as well as the deadline for the submission of all current information. Maintaining Active provider status is dependent upon completion of the re-credentialing process prior to the three-year expiration date.

PROTECTIONS AND ACCOUNTABILITY

Our Member's Rights and Responsibilities

Member Rights include those regarding Privacy and Security of our member's medical records, as per HIPAA. For example, members have a right to:

- Receive an accounting of all disclosures of their personal information to third parties
- Receive a written summary or explanation of their health condition
- Review, copy, and amend incorrect data in their medical records

We have also included member rights specific to Advance Directives. For example, no member shall be discriminated against for filing or not filing an Advance Directive. Members have a right to file an advance directive and have their wishes respected.

America's 1st Choice strongly endorses the rights of members as supported by State and Federal laws as well as other regulatory agencies. The Plan regularly communicates its expectations of members to be responsible for certain aspects of the care and treatment they are offered and receive. In turn, America's 1st Choice requires that all of its providers acknowledge and reinforce our member's rights and responsibilities.

Please note: As a provider, you may deny a member access to their medical records if you believe it could endanger them or someone else's physical safety, for some psychotherapy notes, for information compiled for a lawsuit, or for certain other limited circumstances.

Please contact your Provider Relations representative if you have questions about this provision of the law. For a full list of Member Rights and Responsibilities, please refer to our websites at:

https://sch.americas1stchoice.com → About Us → Utilization & Quality → Member Rights and Responsibilities

LAB **REMINDER**

Quest Laboratory
www.questdiagnostic.com
866-697-8378

Solstas
www.solstas.com
888-664-7601

Laboratory Services of America (LabCorp)
www.labcorp.com
800-432-6078

TIP: Lab and pathology tests for America's 1st Choice members performed at a participating facility can improve HEDIS® scores.

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America's 1st Choice of South Carolina, Inc.

AFC CONNECT

HMO Provider Newsletter

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