A publication to keep our network providers informed on the latest Blue Advantage (HMO) news

Blue Advantage (HMO)

Insight Newsletter

December 2016

In this edition:

HMO Louisiana

BLUE Advantage

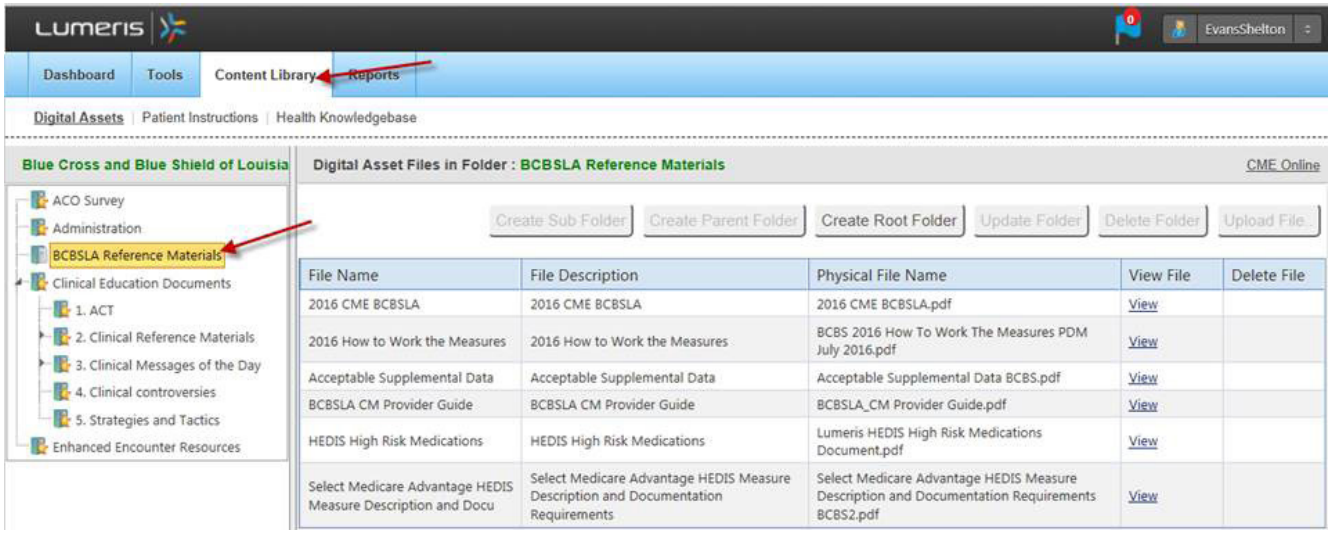
Accountable Delivery System Platform (ADSP) Content Library

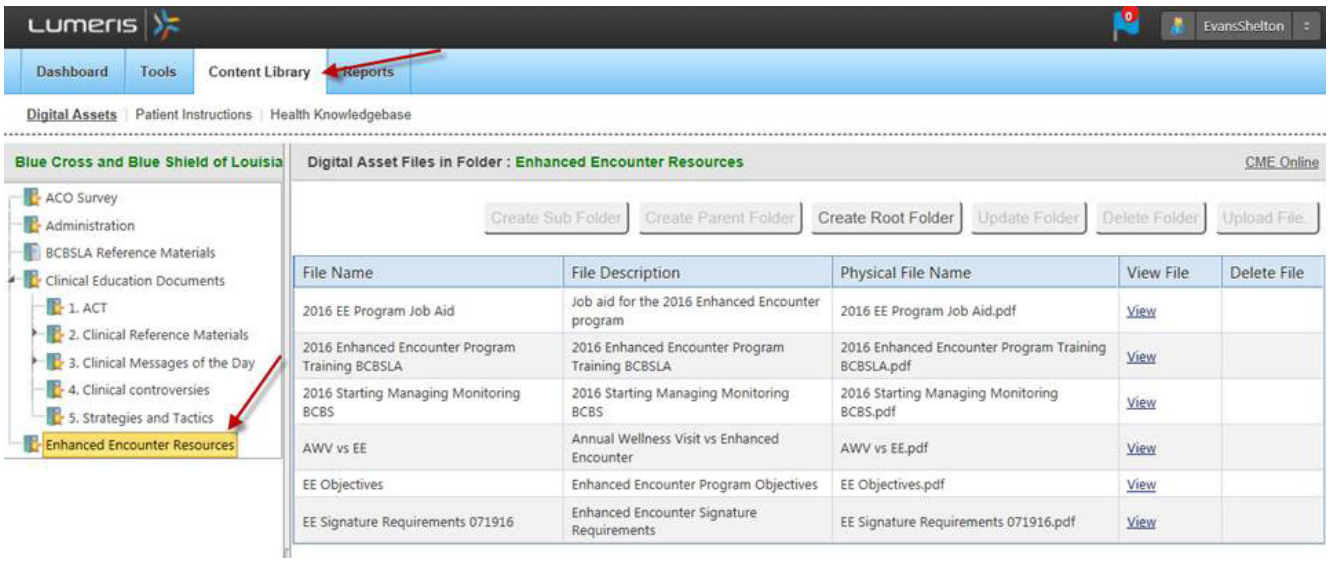
The Content Library on Lumeris' Accountable Delivery System Platform (ADSP) has a variety of reference materials to help primary care providers (PCPs) with Blue Advantage (HMO) needs. The information on the ADSP is provided in a series of reports and criteria-driven rules that allow a unique vantage point into the patient's health status across the entire continuum of care. This platform sends clinical and financial data to physicians and other stakeholders at the point of medical decision making to enable timely value-based healthcare decisions.

The Content Library includes Blue Cross reference materials, Enhanced Encounter resources and much more. Log into your ADSP account to view the materials in the Content Library.

Access to the ADSP is located within the Blue Advantage Provider Portal and available to PCPs only. PCPs must have a username and password to access the ADSP. Once registered to access the ADSP, go to www.bcbsla.com/ilinkblue >Blue Advantage >Blue Advantage Provider Portal where you will find a link to the ADSP.

Beginning in 2017, each provider will need to register a security administrative representative with Blue Cross to access iLinkBlue, the Blue Advantage Provider Portal and the ADSP. See Page 4 of this newsletter for more information.





Part D Prescriber Enrollment Requirement Update – Enforcement Delay

If you are a physician or other eligible professional who writes prescriptions for Part D drugs, Centers for Medicare & Medicaid Services (CMS) regulations now require you to be enrolled in Medicare as an approved status. Initially, CMS announced the enforcement date would begin February 1, 2017. However, recent communications released by CMS states the full enforcement of the Part D Enrollment Requirement has been delayed to January 1, 2019.

CMS is implementing a multifaceted approach to ensure enforcement of the enrollment requirement by January 1, 2019. Leading up to the full enforcement date, CMS will continue to assert efforts to increase prescriber enrollment.

The first stage of enforcement will take place during 2017 with the "Precluded Provider List." The list will include prescribers who are:

- currently excluded by the Office of Inspector General (OIG)
- revoked by the Medicare program
- non-enrolled prescribers with a felony conviction within the last 10 years

Also in 2017, CMS will further ease the enrollment application process, allowing prescribers to review, update, electronically sign and submit pre-populated enrollment applications online.

Additional strategic actions include targeted risk-based prescriber outreach, direct mailing to all non-enrolled prescribers and current education and outreach efforts.

Although the full enforcement is January 2019, CMS strongly recommends that Part D drug prescribers enroll now.

For more information, please visit CMS' website (www.cms.gov) or email providerenrollment@cms.hhs.gov.

Free Continuing Medical Education Credits Opportunity

There's still time to take advantage of the FREE continuing medical education (CME) credits we are offering directly through the Washington University CME portal. Click here for detailed instructions on accessing the CME portal.

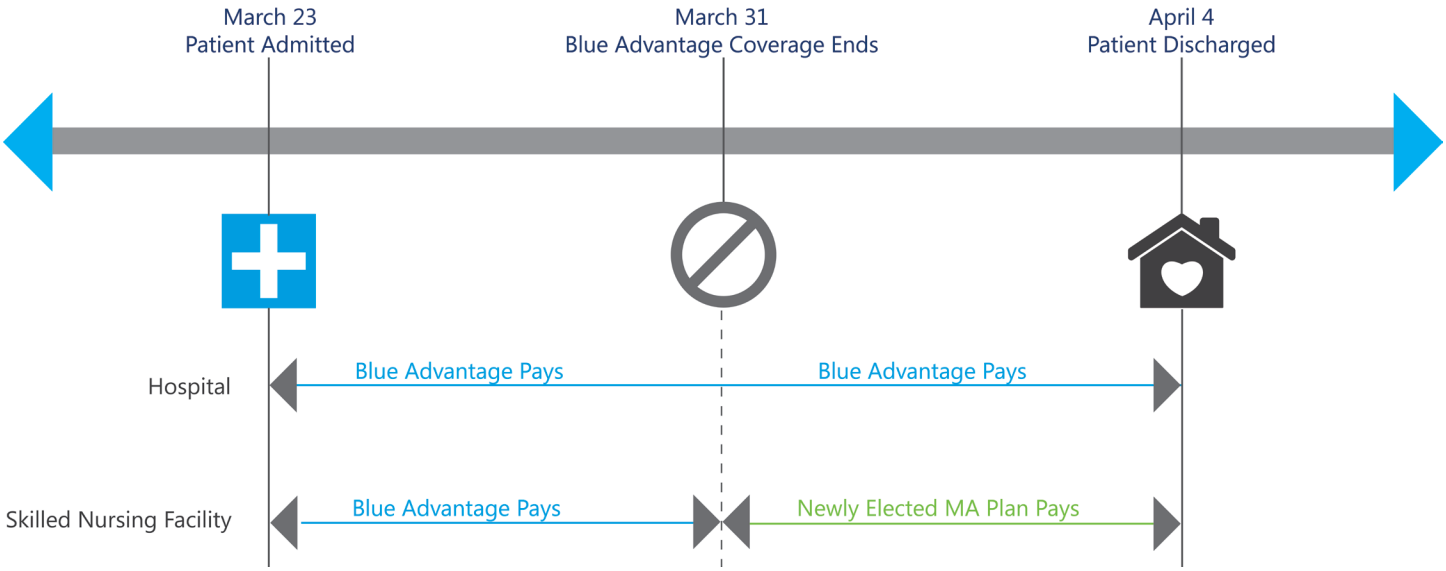
Tips to Know

For assistance with routine inquiries such as claim status, member eligibility, benefit verification or confirmation of prior authorization, use the Blue Advantage Provider Portal, located within iLinkBlue (www.bcbsla.com/ilinkblue). For technical questions relating to the Blue Advantage Provider Portal, you may contact the Technical Support Help Desk at 1-866-397-2812.

Hospital and Skilled Nursing Facility Admits

If a Blue Advantage (HMO) member is admitted to the hospital, and his/her Blue Advantage coverage terminates before the discharge date, who is responsible for payment?

According to the Code of Federal Regulations (42 CFR) Section 422.318, it depends on the type of facility. On an inpatient hospitalization, if a Blue Advantage member's coverage terminates during the stay, the entire stay will be covered until discharge as long as it was initially authorized. In a skilled nursing facility, the day the member's coverage terms, is the last day Blue Advantage will cover. See below example:



Will you be able to see your remittance information in iLinkBlue in 2017?

If you do not have a security administrative representative registered with us before the switch to the new iLinkBlue in 2017, you will lose access to:

- remittance and payment information
- member eligibility
- claims information
- authorizations
- and more

How to Register an Administrative Representative

To set up your administrative representative, please complete this packet and return it to the Provider Identity Management Team. If you received a packet that asked for your 5-digit iLinkBlue number please know that it is not required and we have removed it from the packet.

Webinar for Accessing Blue Cross' Secure Online Services

We are holding webinars to give you step-by-step instructions that you must complete now to ensure that you have access to our secure online services in 2017. Early registration is important as space is limited to 150 participants per webinar date. Remaining webinar dates:

Date	Time	Meeting Number	Meeting Link
Thursday, December 15	10 - 11:30 a.m.	807 672 495	Click here to register
Wednesday, December 21	9 - 10:30 a.m.	802 345 983	Click here to register

High-risk Discharge Case Management Services

As a partner in managing the health needs of our members, Blue Advantage (HMO) offers a variety of case management services, in coordination with the primary care provider (PCP), to assist our members in receiving post-discharge follow-up care:

- **Discharge Reminder Calls**
  A health outreach specialist attempts to call a high-risk patient within three days of discharge to assist the member in setting up a follow-up appointment with the PCP.
- **Transition of Care Program**
  High-risk members can enroll to help prevent avoidable hospital readmissions. The program includes intensive education on disease warning triggers and red-flag symptoms as well as medication reconciliation.

The physician-led interdisciplinary case management team includes health outreach specialists, nurse case managers, social workers, behavioral health specialists and clinical pharmacists.

Discharge planning should include scheduling a follow-up visit with the PCP within 10 days of discharge to reduce the risk of readmission, especially for the following high-risk diagnoses:

- cardiac arrhythmia
- chronic obstructive pulmonary disease or asthma
- congestive heart failure
- deep venous thrombosis
- dehydration
- diabetes mellitus
- pneumonia
- pulmonary embolism
- urinary tract infection

For a list of ICD-10 and drug codes for high-risk discharges, please check the ADSP, available on the Blue Advantage Provider Portal accessible through iLinkBlue (www.bcbsla.com/ilinkblue).

For more information on high-risk discharge case management services, call 1-866-508-7145, option 4, option 4.

Tips to Know

The Accountable Care Team (ACT) Specialist is a specialized representative whose role is to assist PCPs with issues related to the Accountable Delivery System Platform (ADSP), as well as help PCPs with improving their performance measures. ACT Specialists also reach out to Blue Advantage network PCPs.

2017 Quality and Utilization Access Contract Measures

Blue Advantage Primary Care Incentive Program

We are updating the Quality and Utilization Access Contract Measures of the Blue Advantage Primary Care Incentive Program for performance year 2017 that begins on January 1. Below you will find a listing of the performance measures, the 2017 performance target and the per member per month (PMPM) bonus for successfully achieving the performance target.

We removed two 2016 measures:

- High Risk Medications: Two Prescriptions
- Generic Dispense Rate

We are adding two new measures (highlighted in light blue):

- Diabetes: Statin Use
- CVD: Statin Use for Secondary Prevention

Performance Measures	2017 Performance Target	PMPM Bonus
Diabetes: AIC <=9	CMS 4 Star Level	$1.00
Diabetes: Eye Exam	CMS 4 Star Level	$0.50
Diabetes: Nephropathy Monitoring	CMS 4 Star Level	$0.50
Diabetes: Statin Use	CMS 4 Star Level	$0.50
Established Members: PCP Visit	95% of all established patients seen within the performance year	$0.50
High-risk Discharge/PCP Follow-up	55% of high-risk members receive PCP follow-up care within 10 days of discharge	$0.50
Hypertension: Blood Pressure Control	CMS 4 Star Level	$1.00
Med Adherence: Diabetes	CMS 4 Star Level	$1.00
Med Adherence: RAS Antagonists	CMS 4 Star Level	$1.00
Med Adherence: Statins	CMS 4 Star Level	$1.00
CVD: Statin Use for Secondary Prevention	CMS 4 Star Level	$0.50

If you have any questions regarding the Quality and Utilization Access Contract Measures of the Primary Care Incentive Program, please contact the Accountable Care Team Specialist for your respective region:

New Orleans and Northshore
Christie Julian
(504) 453-9884
cjulian@blueadvantage.bcbsla.com

Baton Rouge and Lafayette
Lenora Howard
(225) 590-2513
lhoward@blueadvantage.bcbsla.com

Is Your Information Up-to-Date?

We recently mailed a letter that included a copy of our Provider Update Request Form and asked you to complete the form if there have been any changes with your practice. This form is sent out biannually to ensure we have your most accurate information available to members. Updates may include changes in address or hours of operation. If you have recently had changes to your practice, let us know by completing the form and returning it to Blue Cross. The form is available online at www.bcbsla.com/providers >Forms for Providers.

Reminders

Compliance Responsibilities

As a Medicare Advantage Organization (MAO) with an established contract with the Centers for Medicare and Medicaid Services (CMS), Blue Advantage (HMO) is required to communicate its compliance program requirements to providers and ensure compliance with these requirements.

Providers contracted with Blue Advantage to provide medical or administrative services to our members are required to comply with all applicable Medicare laws, regulations, reporting requirements and CMS instructions, with all other applicable federal, state and local laws, rules and regulations; to cooperate with Blue Advantage in its efforts to comply with the laws, regulations and other requirements of applicable regulatory authorities; and to ensure that all healthcare professionals employed by or under contract to render health services to Blue Advantage members, including covering physicians, comply with these provisions.

Compliance Requirements

As a Blue Advantage network provider you are required to:

- Follow the provider guidelines in your *Blue Advantage (HMO) Provider Administrative Manual* when discussing Medicare Advantage
- Routinely check for exclusions by the Office of Inspector General (OIG)/General Services Administration (GSA)
- Verify that provider training has been completed in:
  - General compliance
  - Fraud, waste and abuse (FWA)
- Report any actual or suspected compliance concerns
- Notify us of any practice information changes immediately

Refer Your Blue Advantage Members to Blue Advantage Providers

Please refer your Blue Advantage patients to network providers as these members do not have out-of-network benefits except:

- when the service is authorized to be delivered by a non-participating provider
- during a state of emergency

Members may research providers in their network at www.bcbsla.com/blueadvantage.

Tips to Know

Blue Advantage provides coverage for prescription medications and members may have their prescriptions filled through a wide network of pharmacies, including mail order. Data shows that a 90-day prescription improves patient adherence, lowers the cost of care and helps patients to achieve better health outcomes. Please refer your Blue Advantage patients to their provider directory for a comprehensive list of participating pharmacies.

Reminders

Non-discrimination Reminder

As a Blue Advantage (HMO) network provider, you have agreed to the following non-discrimination rules for your Blue Advantage patients:

(1) not to deny, limit, condition, differentiate or discriminate in its provision of services to Blue Advantage members because of

race	sexual orientation
color	health status*
national origin	source of payment
enrollees' complaint or grievance in connection with any evidence or certificate of coverage	ancestry
religion	disability
sex	age
marital status	or whether or not a Blue Advantage member has executed an advanced directive

(2) to render services to enrollees in the same manner, in accordance with the same standards, and within the same time availability as offered to non-plan patients consistent with existing medical ethical/legal requirements for providing continuity of care to any patient.

Without limiting the generality of the foregoing, provider expressly agrees to comply with Title VI of the Civil Rights Act of 1964 and 45 C.F.R. 84; the Age Discrimination Act of 1975 and 45 C.F.R. 91; the Americans with Disabilities Act, and its amendments; the Rehabilitation Act of 1973; other laws applicable to recipients of federal funds; and all other applicable federal and state laws, rules and regulations. Without limiting the generality of the foregoing, providers shall make its services available to Blue Advantage members on the same basis and time limits as those made available to patients who are not members of a plan (42 C.F.R. § 422.110).

Hold Harmless for Dual Eligible Members

Members eligible for both Medicare and Medicaid shall not be held liable for Medicare Part A and B cost sharing when the state is responsible for paying such amounts. Provider may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under Title XIX of the Social Security Act if the individual were not enrolled in such a plan.

Provider must:

a) accept Plan's payment as payment in full, or

b) bill the appropriate state source (42 C.F.R. § 422.504(g)(1)(iii))

**Includes, but is not limited to, medical condition, including mental as well as physical illness, claims experience, receipt of healthcare, payor identity, medical history, genetic information and evidence of insurability, including conditions arising out of acts of domestic violence.*