Quality Blue – Condition Assessment Program

For the listening benefit of webinar attendees, we have muted all lines and will be starting our presentation shortly.

- This helps prevent background noise (e.g., unmuted phones or phones put on hold) during the webinar.
- This also means we are unable to hear you during the webinar.
- Please submit your questions directly through the webinar platform only.

How to submit questions:

- Open the Q&A feature at the bottom of your screen, type your question related to today's training webinar and hit "enter."
- Once your question is answered, it will appear in the "Answered" tab.
- All questions will be answered by the end of the webinar.

June 2025

Quality Blue - Condition Assessment Program

Evolving Incentives for Medicare Advantage

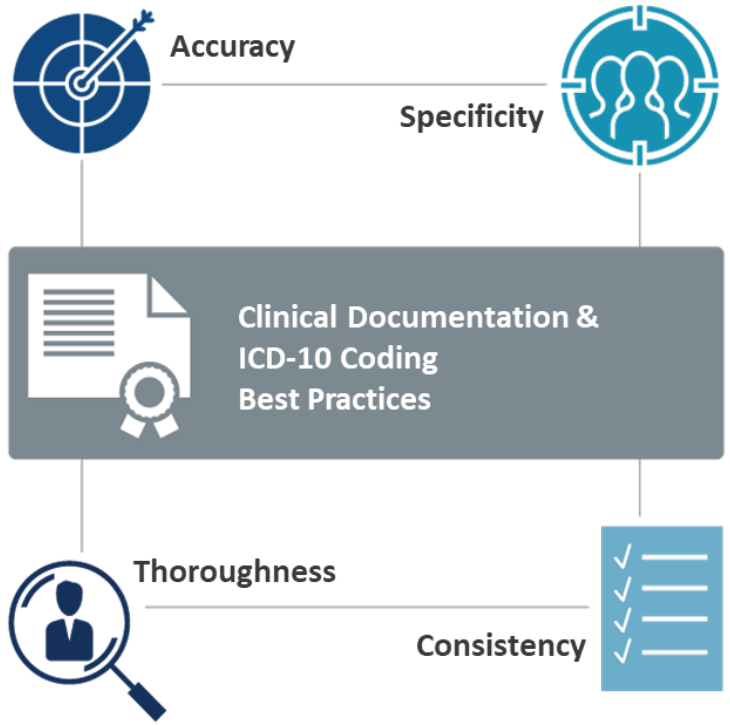
LOUISIANA BLUE

Blue adVantage (HMO) | Blue adVantage (PPO)

Y0132_25735PVLA_C

Best Practices in Medical Record Documentation

- Documentation needs to be sufficient to support and substantiate coding for claims or encounter data.
- Chronic conditions need to be reported every calendar year including key condition statuses (e.g., leg amputation and/or transplant status must be reported each year).
- Include condition specificity where required to explain severity of illness, stage or progression (e.g., staging of chronic kidney disease).
- Treatment and reason for level of care needs to be clearly documented; chronic conditions that potentially affect the treatment choices considered should be documented.



Importance of Complete and Accurate Clinical Documentation and ICD-10 Coding

- Providers treating sicker populations have higher average cost and utilization per patient. Risk-adjusted reporting can accurately reflect these sicker patients.
- The Centers for Medicare and Medicaid Services (CMS) sets risk scores for a calendar year based on diagnoses from the previous calendar year.
- All existing diagnoses must be submitted every calendar year for risk scores to be accurate.
- Member attribution is done by wellness exams.

Importance of Primary Care Providers

The PCP should:

- Develop and grow the provider-member relationship while being proactive and cost effective.
- Oversee, coordinate, discuss and direct the member's care with the member's care team, specialists and hospital staff.
- Assist in coordinating the member's medically necessary services.

When a member changes PCPs, upon request, the prior PCP has 10 business days of the request to submit records to new PCP.

Members who have a strong relationship with their PCPs are healthier, more adherent to their medication regimen and less likely to be hospitalized.

Quality and Experience of Outpatient Care in the United States for Adults With or Without Primary Care:
https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2721037

Primary care visits increase utilization of evidence-based preventative health measures:
https://bmcprimcare.biomedcentral.com/articles/10.1186/s12875-020-01216-8

Provider-Patient Relationships

Maintaining good provider-patient relationships are important, particularly when a patient receives a survey from CMS asking about their experience with their personal provider.

Think about how your patients would respond to questions like these:

- Did your personal provider make things easy to understand?
- Did your personal provider listen carefully to your concerns and show respect for them?
- Did your personal provider spend enough time with you?
- Did your personal provider talk to you about your prescription drugs?

Importance of Annual Wellness Visits

- Provides the ability to effectively assess your patients' chronic conditions, as well as close care and coding gaps for Blue Advantage patients.
- Covered at 100%, **once every calendar year**, for Blue Advantage patients.

<u>Quality</u>

- Assess and capture outstanding Star Rating care gaps for value-based contract performance and better patient outcomes.

<u>Risk Adjustment</u>

- Greater appointment time allotment for comprehensive assessment and care planning for chronic conditions.

Coding for Annual Wellness Visits

- **G0438:** Initial Annual Wellness Visit (AWV)
- **G0439:** Subsequent AWV
- **G0402:** Initial Preventative Physical Examination (IPPE)
- **G0468:** FQHC Encounter for AWV or IPPE
- **ICD-10:** Z00.00 or Z00.01 medical examination with or without abnormal findings and all applicable diagnoses

For telemedicine visits, bill appropriate wellness visit CPT® code **(Modifier 95 and POS 10)**.

More information about these codes can be found on CMS.gov at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html#IPPEsits

Healthy Rewards Program for Your Patients

Help your patients earn Healthy Rewards to congratulate them for taking steps on a journey to better health!

- Blue Advantage's Healthy Rewards program is an easy way for members to earn extra money on their Flex Card – just by completing a few preventive services such as an Annual Wellness Visit or flu shot.
- The Healthy Rewards program is simple. Blue Advantage members who enroll in our program will receive educational information, tools and reminders to help them make the most of their preventive benefits.
- Members must enroll in the program each plan year in order to participate. All eligible health actions must be completed by Jan. 31 to receive funds for that plan year.

- Annual Wellness Visit - $50
- Breast Cancer Screening (Mammogram) - $50
- Colorectal Cancer Screening (Colonoscopy or Flexible Sigmoidoscopy) - $50
- Annual Flu Vaccine - $10
- Retinal Eye Exam - $25
- Health Risk Assessment - $25

How Your Patients Receive Healthy Rewards

Opt In to Receive Rewards

The members must log in to their Blue Advantage Member Portal account (bcbslamemberportal.com) and click the Healthy Rewards tab to opt in to the Healthy Rewards program. They can also call our Healthy Rewards servicing team at 1-833-952-2775 to opt in over the phone.

How to Earn Rewards

After completing one of the health actions listed above, the provider will submit a claim to Blue Advantage for processing. The claim must be coded appropriately, processed and paid by Blue Advantage prior to the member earning their reward. There is no out-of-pocket cost to members for in-network preventive services.

How to Use Rewards

The Blue Advantage Flex Card will be loaded with the funds they have earned each week for claims paid by Blue Advantage in the prior week. The Healthy Rewards funds are deposited into their Flex Card's Reimbursements and Incentives purse.

RHC Reporting Requirement – Modifier CG

Rural health clinics (RHCs) shall report Modifier CG (policy criteria applied) on RHC claims and claim adjustments. Providers should report Modifier CG on one line with a medical and/or mental health HCPCS code that represents the primary reason for the medically necessary face-to-face visit. This line should have the bundled charges for all services subject to coinsurance and deductible. If only preventative services are furnished during the visit, report Modifier CG with the preventive service HCPCS code that represents the primary reason for the medically necessary face-to-face visit.

- Medical and preventative services HCPCS codes are billed with revenue code 052X.
- Mental health services HCPCS codes are billed with revenue code 0900.

Claims submitted without Modifier CG will process incorrectly and the provider will need to adjust the claim.

For additional details, please review the following:

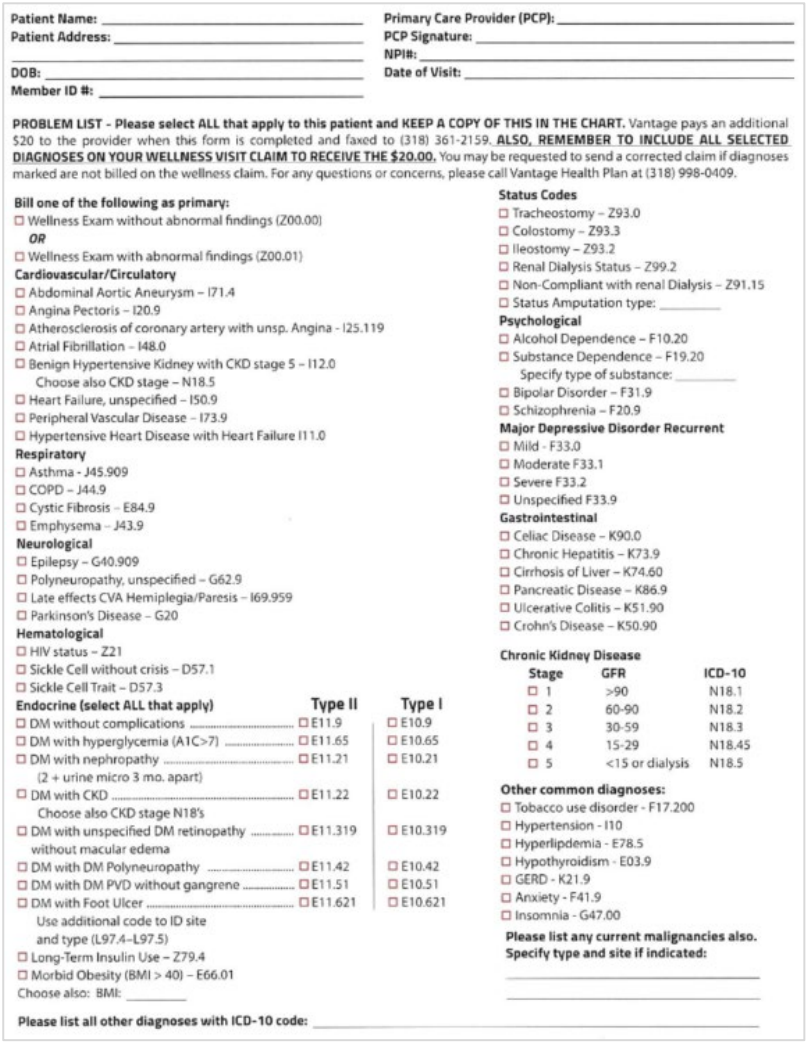
- Rural Health Clinics Reporting Requirements Frequently Asked Questions
- Rural Health Clinic Qualifying Visit List (RHC QVL)

Quality Blue - Condition Assessment Program

Evolving Incentives for Medicare Advantage

Wellness Coupon Program Ending

- Used by Vantage since 2015 and Louisiana Blue since 2020
- Educated on proper billing MA Annual Wellness Visits
- Alerted PCPs to suspect diagnoses
- Incentivized completion of visits



Patient Name: _____ Primary Care Provider (PCP): _____
Patient Address: _____ PCP Signature: _____
_____ NPI#: _____
DOB: _____ Date of Visit: _____
Member ID #: _____

PROBLEM LIST - Please select ALL that apply to this patient and KEEP A COPY OF THIS IN THE CHART. Vantage pays an additional $20 to the provider when this form is completed and faxed to (318) 361-2159. **ALSO, REMEMBER TO INCLUDE ALL SELECTED DIAGNOSES ON YOUR WELLNESS VISIT CLAIM TO RECEIVE THE $20.00.** You may be requested to send a corrected claim if diagnoses marked are not billed on the wellness claim. For any questions or concerns, please call Vantage Health Plan at (318) 998-0409.

Bill one of the following as primary:
- ☐ Wellness Exam without abnormal findings (Z00.00)
- *OR*
- ☐ Wellness Exam with abnormal findings (Z00.01)

Cardiovascular/Circulatory
- ☐ Abdominal Aortic Aneurysm – I71.4
- ☐ Angina Pectoris – I20.9
- ☐ Atherosclerosis of coronary artery with unsp. Angina - I25.119
- ☐ Atrial Fibrillation – I48.0
- ☐ Benign Hypertensive Kidney with CKD stage 5 – I12.0
  Choose also CKD stage – N18.5
- ☐ Heart Failure, unspecified – I50.9
- ☐ Peripheral Vascular Disease – I73.9
- ☐ Hypertensive Heart Disease with Heart Failure I11.0

Respiratory
- ☐ Asthma - J45.909
- ☐ COPD – J44.9
- ☐ Cystic Fibrosis – E84.9
- ☐ Emphysema – J43.9

Neurological
- ☐ Epilepsy – G40.909
- ☐ Polyneuropathy, unspecified – G62.9
- ☐ Late effects CVA Hemiplegia/Paresis – I69.959
- ☐ Parkinson's Disease – G20

Hematological
- ☐ HIV status – Z21
- ☐ Sickle Cell without crisis – D57.1
- ☐ Sickle Cell Trait – D57.3

Endocrine (select ALL that apply)	Type II	Type I
☐ DM without complications	☐ E11.9	☐ E10.9
☐ DM with hyperglycemia (A1C>7)	☐ E11.65	☐ E10.65
☐ DM with nephropathy (2 + urine micro 3 mo. apart)	☐ E11.21	☐ E10.21
☐ DM with CKD Choose also CKD stage N18's	☐ E11.22	☐ E10.22
☐ DM with unspecified DM retinopathy without macular edema	☐ E11.319	☐ E10.319
☐ DM with DM Polyneuropathy	☐ E11.42	☐ E10.42
☐ DM with DM PVD without gangrene	☐ E11.51	☐ E10.51
☐ DM with Foot Ulcer Use additional code to ID site and type (L97.4–L97.5)	☐ E11.621	☐ E10.621

- ☐ Long-Term Insulin Use – Z79.4
- ☐ Morbid Obesity (BMI > 40) – E66.01

Choose also: BMI: _____

Please list all other diagnoses with ICD-10 code: _____

Status Codes
- ☐ Tracheostomy – Z93.0
- ☐ Colostomy – Z93.3
- ☐ Ileostomy – Z93.2
- ☐ Renal Dialysis Status – Z99.2
- ☐ Non-Compliant with renal Dialysis – Z91.15
- ☐ Status Amputation type: _____

Psychological
- ☐ Alcohol Dependence – F10.20
- ☐ Substance Dependence – F19.20
  Specify type of substance: _____
- ☐ Bipolar Disorder – F31.9
- ☐ Schizophrenia – F20.9

Major Depressive Disorder Recurrent
- ☐ Mild - F33.0
- ☐ Moderate F33.1
- ☐ Severe F33.2
- ☐ Unspecified F33.9

Gastrointestinal
- ☐ Celiac Disease – K90.0
- ☐ Chronic Hepatitis – K73.9
- ☐ Cirrhosis of Liver – K74.60
- ☐ Pancreatic Disease – K86.9
- ☐ Ulcerative Colitis – K51.90
- ☐ Crohn's Disease – K50.90

Chronic Kidney Disease

Stage	GFR	ICD-10
☐ 1	>90	N18.1
☐ 2	60-90	N18.2
☐ 3	30-59	N18.3
☐ 4	15-29	N18.45
☐ 5	<15 or dialysis	N18.5

Other common diagnoses:
- ☐ Tobacco use disorder - F17.200
- ☐ Hypertension - I10
- ☐ Hyperlipdemia - E78.5
- ☐ Hypothyroidism - E03.9
- ☐ GERD - K21.9
- ☐ Anxiety - F41.9
- ☐ Insomnia - G47.00

Please list any current malignancies also. Specify type and site if indicated:
_____
_____

Wellness Coupon Program Ending

Louisiana Blue spent 2024 evaluating the effectiveness of the Wellness Coupon program after frequent provider feedback indicated its limitations.

Limitations of Coupon Program

- Paper Based
- Limited scalability
- Extra work for PCP and Plan to complete and reconcile
- Poor distribution tool for suspect DX

In 2025, the Blue Advantage Wellness Coupon Program was replaced by the new Quality Blue – Condition Assessment Program.

Coupons for 2024 DOS were accepted through Feb. 28, 2025.

QB CAP components

Annual Wellness Visit (AWV) Completion

Incentive of $60 per completed AWV, available to all network PCPs

Condition Assessment: Two Avenues

1. Condition Assessment via Epic – Incentive of $40 per condition assessed
2. Condition Assessment Via Stellar Health platform – Incentive of $40 per condition assessed*

*minimum attribution requirements to participate

QB CAP: AWV participation only

Providers who do not participate in condition assessment with Epic or Stellar and have 10+ members are eligible for an escalating Annual Incentive for reaching thresholds of AWV completion.

Panel AWV Completion incentive increase:

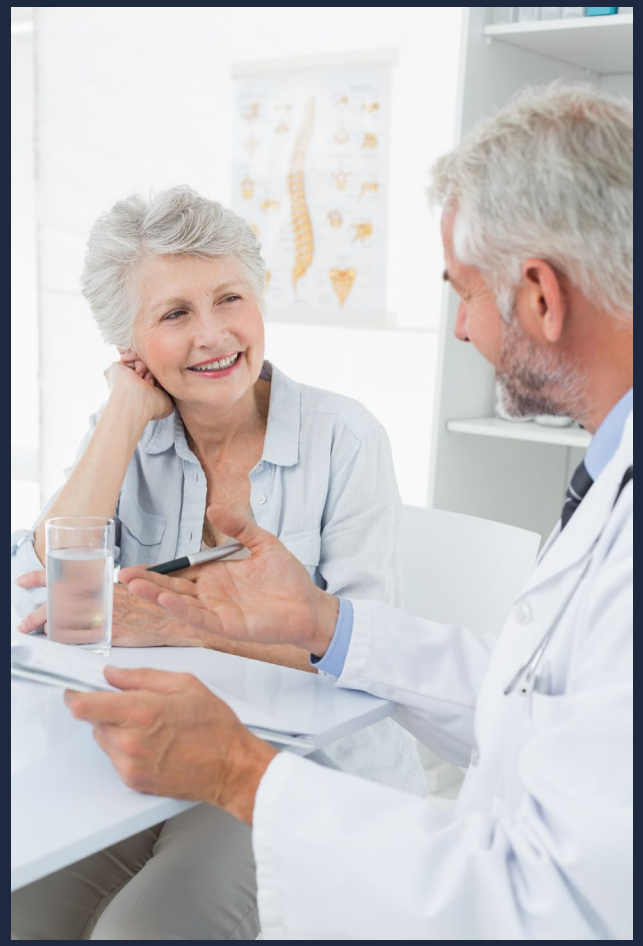
- Over 50% - $5 PMPY
- Over 60% - $15 PMPY
- Over 80% - $20 PMPY
- Over 90% - $25 PMPY

Pay for Performance (P4P) Medicare Advantage Star Rating Incentive

4 Star: $50 PMPY

5 Star: $100 PMPY

Note: Payments are Risk Adjusted



All PCPs participating in our Blue Advantage network(s) are eligible to receive performance incentive payments based on closing gaps in care for CMS HEDIS® measures.

Effective in 2024, Star Ratings will be evaluated at the QB group or Tax ID Number (TIN) level.

2025 MA Star Measures Changes

Measures are categorized as Foundational, Enhanced and High Focus:

Measure	Category	Factor
Breast Cancer Screening (BCS)	Foundational	1.0
Colorectal Cancer Screening (COL)	Foundational	1.0
Kidney Health Evaluation for Patients with Diabetes (KED)	Foundational	1.0
Medication Adherence for Diabetes Medications (ADH- Diabetes)	Foundational	1.0
Medication Adherence for Hypertension (ADH- RAS Antagonists)	Foundational	1.0
Medication Adherence for Cholesterol (ADH- Statins)	Foundational	1.0
Eye Exam for Patients with Diabetes (EED)	Enhanced	0.5
Hemoglobin A1c for Patients with Diabetes (HBD)	Enhanced	0.5
Controlling High Blood Pressure (CBP)	Enhanced	0.5
Plan All-Cause Readmissions (PCR)	Enhanced	0.5
Statin Therapy for Patients with Cardiovascular Disease (SPC)	High Focus	1.5
Statin Use for Patients with Diabetes (SUPD)	High Focus	1.5

- **Foundational:** Measured using claims data. **These measures carry a factor of 1.0**.
- **Enhanced:** More advanced and may require the exchange of clinical data or medical coding including applicable CPT II codes as defined by measure, in the absence of a data feed. **These measures carry a factor of 0.5**.
- **High Focus:** Those where members have a significant need to improve health outcomes. These are medication measures. **These measures carry a factor of 1.5**.

2025 MA Star Measures Changes

Sample Scorecard - *For illustrative purposes only*

Measure	Category	Num.	Den.	Rate	Star	Weight[(1)]	Factor	Weight * Factor	Star * Weight * Factor
		A	B	A/B = C	D	E	F	E*F	D*E*F
Breast Cancer Screening (BCS)	Foundational	40	50	80%	5	10	1	10	50
Colorectal Cancer Screening (COL)	Foundational	70	100	70%	3	10	1	10	30
Kidney Health Evaluation for Patients with Diabetes (KED)	Foundational	25	30	83%	4	10	1	10	40
Medication Adherence for Diabetes Medications (ADH- Diabetes)	Foundational	23	30	76%	4	10	1	10	40
Medication Adherence for Hypertension (ADH- RAS Antagonists)	Foundational	29	30	97%	5	10	1	10	50
Medication Adherence for Cholesterol (ADH- Statins)	Foundational	5	7	71%	4	7	1	7	28
Eye Exam for Patients with Diabetes (EED)	Enhanced	61	70	87%	3	10	0.5	5	15
Hemoglobin A1c for Patients With Diabetes (HBD)	Enhanced	26	30	87%	3	10	0.5	5	15
Controlling High Blood Pressure (CBP)	Enhanced	62	70	86%	3	10	0.5	5	15
Plan All-Cause Readmissions (PCR)	Enhanced	6	7	86%	4	7	0.5	3.5	14
Statin Therapy for Patients With Cardiovascular Disease (SPC)	High Focus	6	7	86%	4	7	1.5	10.5	42
Statin Use for Patients With Diabetes (SUPD)	High Focus	6	7	86%	4	7	1.5	10.5	42
								H	I
Total Weights								**97**	**381**

Star Rating Unrounded					**3.95**	I/H
Rounded Star Rating	★	★	★	★		

(1) **If denominator is over 10, a weight of 10 is applied. Otherwise weight is denominator.**

2025 MA Star Measures Changes

Retired Measures

- Diabetes Care-Hemoglobin A1C Test
- Care of Older Adults measures
- Osteoporosis Management in Women who had a Fracture

New Measures

- Diabetes Care-Blood Sugar Controlled
- Controlling High Blood Pressure
- Plan All Cause Readmissions

CPT II Resources for new Star Measures

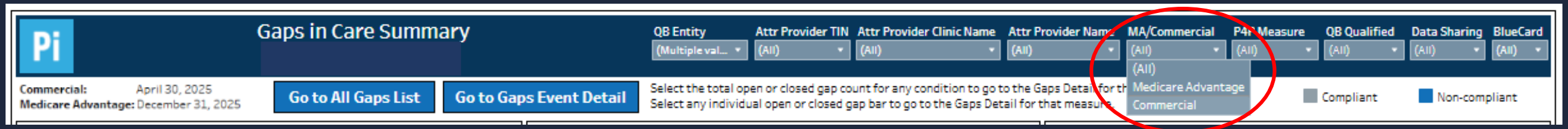
Measure	Definition	CPT II Codes
Controlling High Blood Pressure	The percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (< 140/90 mmHg) during the measurement year.	3074F (systolic < 130 mmHg) 3075F (systolic = 130-139 mmHg) 3077F (systolic ≥ 140 mmHg) 3078F (diastolic < 80 mmHg) 3079F (diastolic = 80-89 mmHg) 3080F (diastolic ≥ 90 mmHg)
Controlling Blood Sugar	The percentage of members 18-85 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was > 9% during the measurement year.	3044F A1c < 7% 3046F A1c > 9% 3051F A1c ≥ 7% and < 8% 3052F A1c ≥ 8% and ≤ 9%

Performance Insights Portal - Blue Advantage

Quality Blue Contracted Providers: To support the development of standard workflows around your Louisiana Blue Population, the following PI dashboards now include Blue Advantage member data:

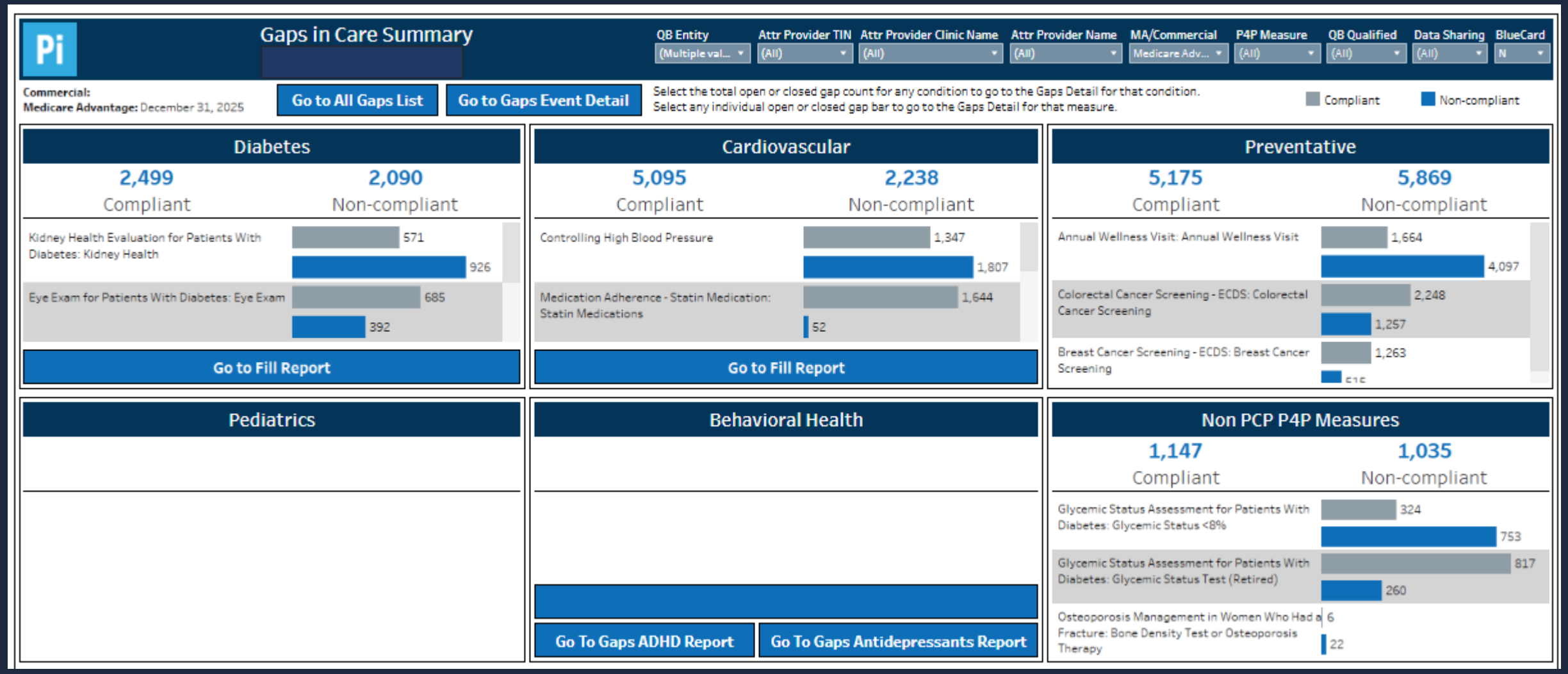
- Gaps in Care
- Patient Panel
- Patient Profile
- Clinical Pharmacy, ADT, Lab and Telemedicine

For Gaps in Care Select Filters as Follows:



Choose *Medicare Advantage* under **MA/Commercial Filter**

Medicare Advantage Gaps in Care



Performance Insights Portal - Blue Advantage

Providers who do not have access to the Performance Insights Portal will continue to receive reporting directly from Louisiana Blue.

Please contact your Blue Advantage Value Program Representative or **BAValueProgramsRep@lablue.com** if you would like additional information related to the Performance Insights portal.

Statin Use in Persons with Diabetes (SUPD)

Measure Description

- Percentage of patients with diabetes receiving statin therapy

Calculation (numerator/denominator)

- **Numerator**: Number of patients in the denominator who received *any* statin medication fill during the current measurement year
- **Denominator**: Number of patients 40-75 years old with at least two diabetes medication fills, on two separate dates, during the current measurement year

Measure Rationale

- The American Diabetes Association (ADA) Standards of Medical Care in Diabetes recommends the use of a statin regardless of lipid levels in patients 40-75 years of age with diabetes.
- These patients without additional ASCVD risk are recommended to use a moderate-intensity statin.
- Patients with ASCVD and diabetes are recommended to use a high-intensity statin.

Exclusion Criteria and ICD-10-CM Codes

- **Hospice**
- **ESRD or Dialysis***:* I12.0, I13.11, I13.2, N18.5, N18.6, N19, Z91.15, Z99.2
- **Myopathy***:* G72.0, G72.89, G72.9
- **Rhabdomyolysis:** M62.82
- **Pre-diabetes**: R73.03, R73.09
- **Liver Cirrhosis***: K70.30, K70.31, K71.7, K74.3, K74.4, K74.5, K74.60, K74.69, P78.81*
- ***PCOS:*** *E28.2*
- **Pregnancy, lactation, or infertility**: Please call Clinical Pharmacy Services toll-free at 1-833-955-3820 (TTY 711) Monday - Friday from 8 a.m. to 5 p.m. for qualifying ICD-10 codes.

Statin Therapy for Patients with Cardiovascular Disease (SPC)

Measure Description

- Percentage of patients with clinical atherosclerotic cardiovascular disease (ASCVD) receiving statin therapy

Calculation (numerator/denominator)

- **Numerator**: Patients that were dispensed at least one *high* or *moderate-intensity* statin during the measurement year
- **Denominator**: Males 21-75 years of age and females 40-75 years of age during the measurement year identified as having clinical ASCVD

Measure Rationale

- In members that are 75 years or younger with ASCVD, the American College of Cardiology (ACC) and American Heart Association (AHA) 2018 guidelines recommend a high-intensity statin.
- A moderate-intensity statin is recommended for those who experience statin-associated side effects at a high-intensity dose.

Exclusion Criteria and ICD-10-CM Codes

- **Hospice**
- **Deceased during the measurement year**
- **Palliative Care:** Z51.5
- **ESRD or dialysis**: I12.0, I13.11, I13.2, N18.5, N18.6, N19, Z91.15, Z99.2
- **Myalgia**: M79.10–M79.12, M79.18
- **Myositis**: M60.80, M60.9
- **Myopathy**: G72.0, G72.89, G72.9
- **Rhabdomyolysis**: M62.82
- **Liver Cirrhosis**: K70.30, K70.31, K71.7, K74.3, K74.4, K74.5, K74.60, K74.69, P78.81
- **Pregnancy, infertility or dispensed clomiphene prescription**: Please call Clinical Pharmacy Services toll-free at 1-833-955-3820 (TTY 711) Monday - Friday from 8 a.m. to 5 p.m. for qualifying ICD-10 codes.
- **Members 66 years of age and older**: Institutional SNP (I-SNP) enrolled, living in a long-term care facility, frailty & advanced illness diagnosis, or a dispensed dementia medication

Best Practices to Help Close the Gap in Care

Evaluate Gaps in Care Information

- Identify patients who meet measure criteria and who do not have a statin fill
- Identify which prescribers have the most opportunities for statin initiation

Recommendations to Encourage Appropriate Statin Therapy

- Build alerts into the EMR to notify providers of patients in need of a statin based on diagnoses
- Develop a protocol to initiate statins in patients who meet the criteria

Prescribing Statins

- Prescribe three-month supplies and remind patient to refill on schedule to encourage better adherence
- Utilize mail order and turn on auto-refills when using Express Scripts Pharmacy

Statin Intolerance

- Studies show that almost half of patients can tolerate the same statin upon rechallenge;
  - Rosuvastatin, pravastatin and fluvastatin are the least likely to have drug interactions
- Consider alternate dosing schedule

Blue Advantage Portal Training

Our **Provider Relations Representatives** are available to provide Blue Advantage portal training to providers and their staff.

To request training, please send an email to your provider relations representative or email **provider.relations@lablue.com**. Put “Blue Advantage Portal Training” in the subject line.

Please include your:

- Name
- Organization name
- Contact information
- Brief description of the training you are requesting

Contact Us

Blue Advantage Customer Service

1-866-508-7145

customerservice@blueadvantagela.com

Provider Relations

1-800-716-2299, option 4

provider.relations@lablue.com