# 2020 INTER-PLAN MEDICARE ADVANTAGE CARE MANAGEMENT AND PROVIDER ENGAGEMENT PROGRAM:
# Blue Cross Blue Shield
# Highmark Hosted MA Members

## PROGRAM MANUAL

**This Program Manual is applicable to the following health plans: Highmark Inc., Highmark West Virginia Inc. (Highmark WVA), and Highmark BCBSD Inc. (Highmark DE). Each such health plan is referred to herein as "Highmark".**

**Proprietary and Confidential**

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# PROGRAM OVERVIEW

**Objective**

The purpose of the Inter-Plan Medicare Advantage Care Management and Provider Engagement Program (hereinafter,"Program") for out of area (OOA) Blue Cross Blue Shield ("BCBS") plans whose members are hosted by Highmark is to improve care management and data sharing strategies for the Medicare Advantage (MA) Member population.

**Intent**

The 2020 Program is structured to support and improve the coordination of care on OOA BCBS Medicare Advantage Members within the Highmark provider network
(hereafter, "Hosted Members"). Inter-plan data sharing will include the following key Centers for Medicare and Medicaid Services ("CMS") elements:

1. Care Gap Closure for defined CMS quality metrics
2. Risk Adjustment Programs
3. Healthcare Effectiveness Data and Information Set ("HEDIS") Chart Retrieval Program

**Program Data Criteria**

Highmark network practices participating in the Program (hereafter, "Participants") will be eligible for unique compensation opportunities through the following:

1. Care Gap Closure for defined CMS quality metrics
2. Risk Adjustment program opportunities

**Practice Participation And Compensation**

Program reporting and subsequent compensation payments are based upon the submitted claims data and participation in specific Risk Adjustment programs. Claims submitted to Highmark are required to include accurate and complete coding. Supporting documentation of the claim must be appropriately captured in the patient's medical record. Participants are required to submit the patient's principal diagnoses, as well as all complications and comorbid diagnoses with each claim. Highmark reserves the right to audit any and all claims or data submitted.

Participants shall provide, free of charge, requested medical records or other documentation for the purposes of reporting to external agencies, such as National Committee for Quality Assurance ("NCQA"),HEDIS and CMS.

Participants are required to agree to participate in the Program and to acknowledge review of the Program requirements and conditions, which includes Program intent, measurement, and Program compensation structure details by completing the Program Acknowledgement located on NaviNet. Acknowledgement can be received by Highmark, via NaviNet, at any time during the 2020 calendar year; however, quarterly gap closure payments will not be retroactively paid. No Program payments will be made outside of the established payment cycle. Please reference Appendix A Component Incentive Payment Cycle.

**Attribution**

This Program is dependent on member attribution results of OOA BCBS plans.

Attribution will be defined and identified by the HOSTED Members' OOA BCBS plan, which is the plan to which the member pays their insurance premium.
Highmark does NOT generate the attribution therefore this attribution can/may differ from the Highmark attribution logic.

The identified Hosted Members will NOT be included in Highmark provider incentive program aggregated stars scoring for the measurement year 2020.

# PERFORMANCE MEASUREMENT

Performance measurement requirements for the Program components are outlined below. These requirements will be used to determine whether Participants are eligible for Program compensation.

**Components**

**1. CMS Star Metric Care Gap Closure ("Care Gap Closure") Component**

Program care gaps are defined as Members who have not yet received the expected care as indicated by the NCQA HEDIS® or CMS measurement requirements. Members may have more than one identified care gap based on their measure eligibility as determined by the clinical quality measure specifications.

Technical specifications for claim-based metrics can be found in a separate Medicare Advantage Incentive Program Masthead Measure Guide ("Guide") located on the Provider Resource Center under Medicare Advantage Stars – Medicare Advantage Stars Program. The Guide is provided as an educational resource for Participants to gain an understanding of numerators, denominators and exclusions used in performance measurement. A brief description of the measures is listed under Appendix A. Please consult your Provider Account Liaison or Clinical Transformation Consultant if you have questions on measure specifications.

CMS Star measures will be classified as either "static" or "dynamic" based upon whether or not care gaps can definitively be closed during the Program measurement year. Gap closure results from a one-time activity (static), or final year end submission activity (dynamic). Static measures are closed for a Member when the expected care is provided to that Member once during the measurement year. Dynamic measures may require ongoing member monitoring and population management to ensure that Members have received the expected care for a clinical quality measure.

Sixteen CMS Star measures will be included and assessed for the Care Gap Closure component of the Program:

| **Static Measure ID** | |
|---|---|
| **C01:** | Breast Cancer Screening |
| **C02:** | Colorectal Cancer Screening |
| **C07:** | Adult BMI Assessment |
| **C12:** | Osteoporosis Management in Women Who Had a Fracture |
| **C13:** | Comprehensive Diabetes Care: Eye Exam (retinal) performed |
| **C14:** | Comprehensive Diabetes Care: Medical Attention for Nephropathy |
| **C17:** | Rheumatoid Arthritis Management |
| **C20:** | Medication Reconciliation Post-Discharge |
| **C22:** | Statin Therapy for Patients with Cardiovascular Disease |
| **D13:** | MTM Program Completion Rate for CMR |
| **D14:** | Statin Use in Persons With Diabetes |
| **Dynamic Measure ID** | |
| **C15:** | Comprehensive Diabetes Care: Eye Exam (retinal) performed |
| **C16:** | Controlling High Blood Pressure |
| **D10:** | Medication Adherence for Diabetes Medications |
| **D11:** | Medication Adherence for Hypertension (RAS antagonists) |
| **D12:** | Medication Adherence for Cholesterol (Statins) |

# PERFORMANCE MEASUREMENT, Continued

**Components** (Continued)

Each gap in care that is closed on an eligible static measure-set between January 1, 2020 and December 31, 2020 -will be noted to be eligible for the care gap closure compensation pursuant to this Program. Dynamic measures that hit numerator compliance as of March 27th, 2021 will receive associated gap closure payments pursuant to this Program.

Program Care Gap Closure component compensation payments will be distributed quarterly in June 2020, September 2020, December 2020 and June 2021.

Participants will receive a monthly Member listing report to support care gap closure efforts. These lists will update based upon claims received by OOA BCBS plans (and shared with Highmark for distribution to our network providers) throughout the course of the measurement year.

**NOTE:** Care gaps can open anytime during the measurement year based upon measure specification requirements and the measurement window.

**Supplemental Data Paths**

NOTE: Highmark specific supplemental data sources are NOT open to HOSTED Members as part of this Program. Supplemental data sources are approved by HEDIS auditor for use at a local HOME plan level only.

**Star Measure Care Gap Component Monitoring**

Highmark will provide Participants with summary reports and member care gap listing reports on a monthly basis to aid in care gap closure and population management.

Reference Appendix B: Report Example.

# RESULTS AND COMPENSATION

**Component Results and Compensation Opportunities**

**Care Gap Closure Component**

Each of the static CMS Star measures with care gaps closed by date of service December 31, 2020 is eligible to receive a $10 compensation payment per gap closed.

In addition to the foregoing, note the following compensation enhancements for specific dynamic CMS Star measures that require care management throughout the year. Dynamic measures are scored based upon final calendar year numerator compliance result or percentage of days covered calculations. Due to the nature of these measures, compensation cannot be made until final quarterly gap closure payment cycle.

- Medication Adherence measures (Diabetes, Hypertension, Cholesterol), providers will receive $20 for each member who completes the year with a greater than 80% of days covered.
- Statin Use in Persons with Diabetes (SUPD) member compliance will trigger a $20/member provider compensation payment.
- Comprehensive Diabetes Care HbA1c Controlled (based on last test of the measurement year and a result reported as <9) member compliance will trigger a $10/member provider compensation payment.
- Controlling High Blood Pressure (based on last measurement of the measurement year) member compliance will trigger $10/member provider compensation payment.

All payments will be made to the participating provider practices via electronic fund transfer (EFT) as determined by Tax ID. If the practice is not established for EFT payments a check will be issued to the practice.

**Risk Adjustment Programs**

Highmark currently has multiple risk adjustment programs in which network providers may elect to participate based on the offerings and which program works best with the provider's workflow. The following are Highmark Risk Adjustment Programs:

- Unconfirmed Diagnosis Code (UDC) Program is a clinically based program that promotes Provider/Highmark collaboration to evaluate previously reported and/or suspected diagnosis conditions.

- Enhanced Annual Wellness Visit (eAWV) Program uses the Vatica Wellness 365+ software to perform and document enhanced Annual Wellness Visits for the MA population. This tool assists a provider in appropriate documentation of an annual wellness visit along with

evaluating unconfirmed diagnosis conditions presented.

- Risk Score Accuracy (RSA) Program is designed to work within or in conjunction with the providers EMR system to present unconfirmed diagnosis conditions at the point of care for evaluation, disposition, treatment and documentation when appropriate.

- Retrospective Chart Retrieval Program supports CMS requirement to ensure the accuracy and integrity of risk adjustment data submitted to CMS.

Highmark network providers currently participating in our Risk Adjustment Program's will be eligible to receive compensation for addressing unconfirmed diagnosis codes/conditions for HostedMembers. Please refer to all the Risk Adjustment Program materials located on the Highmark Provider Resource Center for details including compensation regarding each of the programs listed above. Please see Appendix C for access details.

Highmark will incorporate the newly attributed members through the same solution chosen by the Provider for participation of unconfirmed conditions.

To assist with ICD-10-CM coding requirements, Highmark's Risk Revenue Program Management team continues to provide coding support to Participants to assist with proper documentation and coding. The referenced materials and educational training programs can be located on the Highmark Provider Resource Center. Please see Appendix C for access details.

# APPENDIX A:

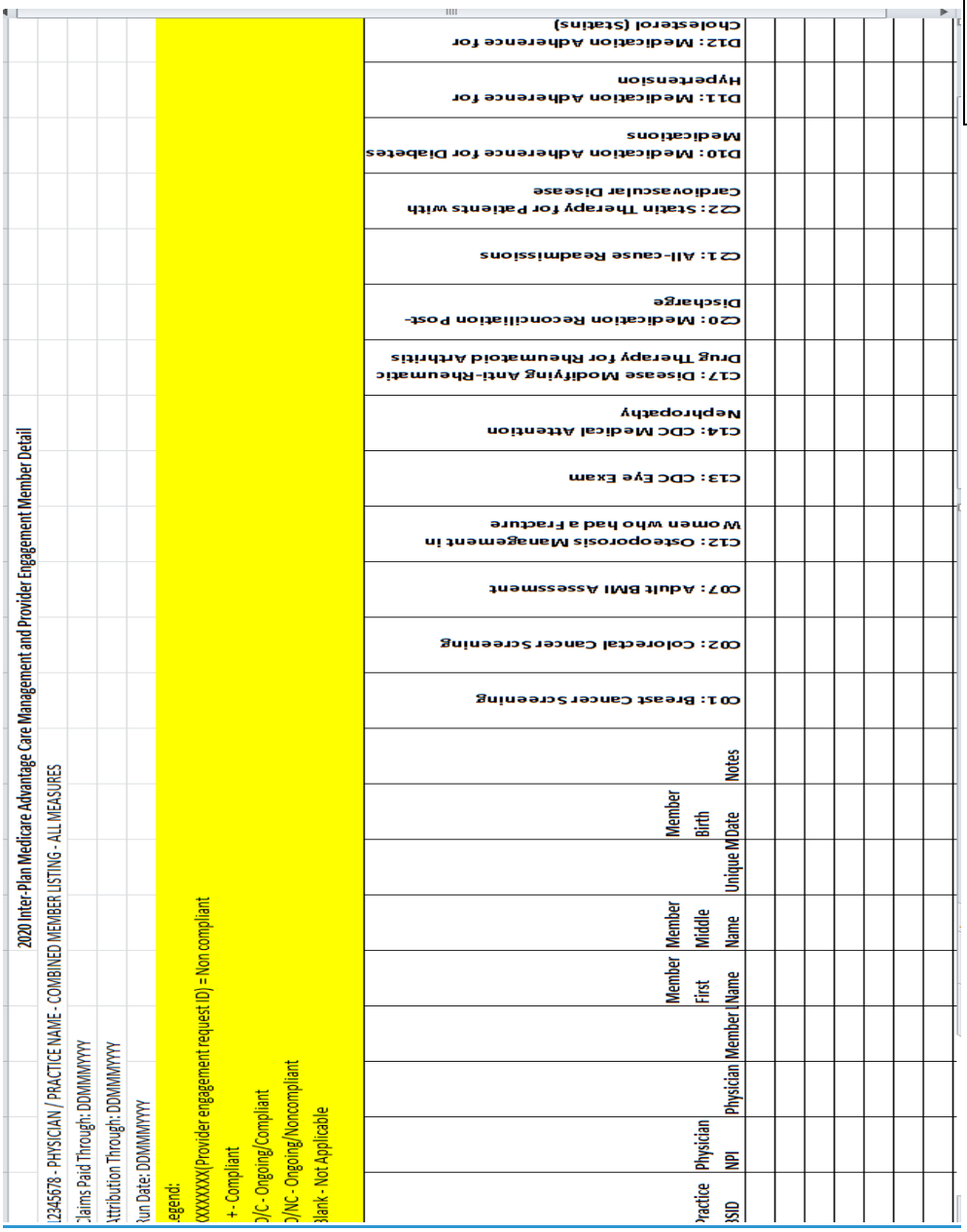
## CMS Stars Measure Set: Measure Descriptions with Eligible Population Criteria

| Static Measure ID | |
|---|---|
| **C01:** | **Breast Cancer Screening**- The percentage of female Members age 50-74 years who had a mammogram to screen for breast cancer. |
| **C02:** | **Colorectal Cancer Screening**- The percentage of members age 50 -75 who had appropriate screening for colorectal cancer. |
| **C07:** | **Adult BMI Assessment-**The percentage of members age 18-74 who had an outpatient visit and whose body mass index (BMI) was documented during the measurement period or the year prior to the measurement year. |
| **C12:** | **Osteoporosis Management in Women Who Had a Fracture**- The percentage of female Members age 67-85 who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat or prevent osteoporosis within 180 days after the fracture. |
| **C13:** | **Comprehensive Diabetes Care: Eye Exam (retinal) performed-** The percentage of diabetic Members age 18-75 who received an eye screening for diabetic retinal disease. |
| **C14:** | **Comprehensive Diabetes Care: Medical Attention for Nephropathy**- The percentage of diabetic Members age 18-75 who had medical attention for nephropathy. |
| **C17:** | **Rheumatoid Arthritis Management-** The percentage of Members age 18 and older who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug ( DMARD) |
| **C20:** | **Medication Reconciliation Post-Discharge-**The percentage of discharges from January 1- December 1 of the measurement year for Member 18 years of age and older for whom medication were reconciled on the date of discharge through 30 days after discharge (31 total days) as evidenced in outpatient chart. |
| **C22:** | **Statin Therapy for Patients with Cardiovascular Disease-**The percentage of male Members age 21-75 and female Members age 40-75 during the measurement period, who were identified as having clinical atherosclerotic cardiovascular disease and were dispensed at least one high or moderate-intensity statin medication during the measurement year. |
| **D13:** | **MTM Program Completion Rate for CMR**-The percentage of Members age 18 and older enrolled in the Medication Therapy Management (MTM) program who received a Comprehensive Medication Review (CMR) during the measurement period. (CMR must be completed and reported in according to the CMS approved MTM program submission for the measurement year.) |
| **Dynamic Measure ID** | |
| **C15:** | **Comprehensive Diabetes Care: Blood Sugar Controlled**- The percentage of Members age 18-75 with diabetes (type 1 or type 2) who's most recent Hemoglobin A1c is ≤9. |
| **C16:** | **Controlling High Blood Pressure**-The percentage of Members 18-85 years of age who had two diagnoses of hypertension (HTN) and whose most recent BP was adequately controlled (<140/90 mm Hg) |
| **D10:** | ***Medication Adherence for Diabetes Medications**- The percentage of Members age 18 and older with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are prescribed to be taking the medication. All diabetic medications with the **exception** of insulin or insulin combination products are included in this measure. |
| **D11:** | ***Medication Adherence for Hypertension (RAS antagonists) -** The percentage of Members age 18 and older with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are prescribed to be taking the medication. Blood pressure medications include: ACEI, ARB, and direct renin inhibitors. |
| **D12:** | ***Medication Adherence for Cholesterol (Statins) -** The percentage of Members age 18 and older with a prescription for cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are prescribed to be taking the medication. |
| **D14:** | ***Statin Use in Persons with Diabetes (SUPD) –** The percentage of Members age 40-75 as of the first date of the measurement year who were dispensed medications for diabetes that received a statin medication. **NOTE**: Paid prescription drug claims are used to identify members as diabetics. |

*Measures that are based on Part D paid and approved claims for both the denominator and numerator compliance

# APPENDIX B: Report Example - Star Practice Level Monthly Report Sample Summary Tab

This is an example and individual reports may vary.



2020 Inter-Plan Medicare Advantage Care Management and Provider Engagement Member Detail

12345678 - PHYSICIAN / PRACTICE NAME - COMBINED MEMBER LISTING - ALL MEASURES

Claims Paid Through: DDMMMYYYY

Attribution Through: DDMMMYYYY

Run Date: DDMMMYYYY

Legend:

(XXXXXXXX(Provider engagement request ID) = Non compliant

+ - Compliant

D/C - Ongoing/Compliant

D/NC - Ongoing/Noncompliant

Blank - Not Applicable

| Practice ID | Physician NPI | Physician | Member | Member First Name | Member Middle Name | Unique MID | Member Birth Date | Notes | C01: Breast Cancer Screening | C02: Colorectal Cancer Screening | C07: Adult BMI Assessment | C12: Osteoporosis Management in Women who had a Fracture | C13: CDC Eye Exam | C14: CDC Medical Attention Nephropathy | C17: Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis | C20: Medication Reconciliation Post-Discharge | C21: All-cause Readmissions | C22: Statin Therapy for Patients with Cardiovascular Disease | D10: Medication Adherence for Diabetes Medications | D11: Medication Adherence for Hypertension | D12: Medication Adherence for Cholesterol (Statins) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
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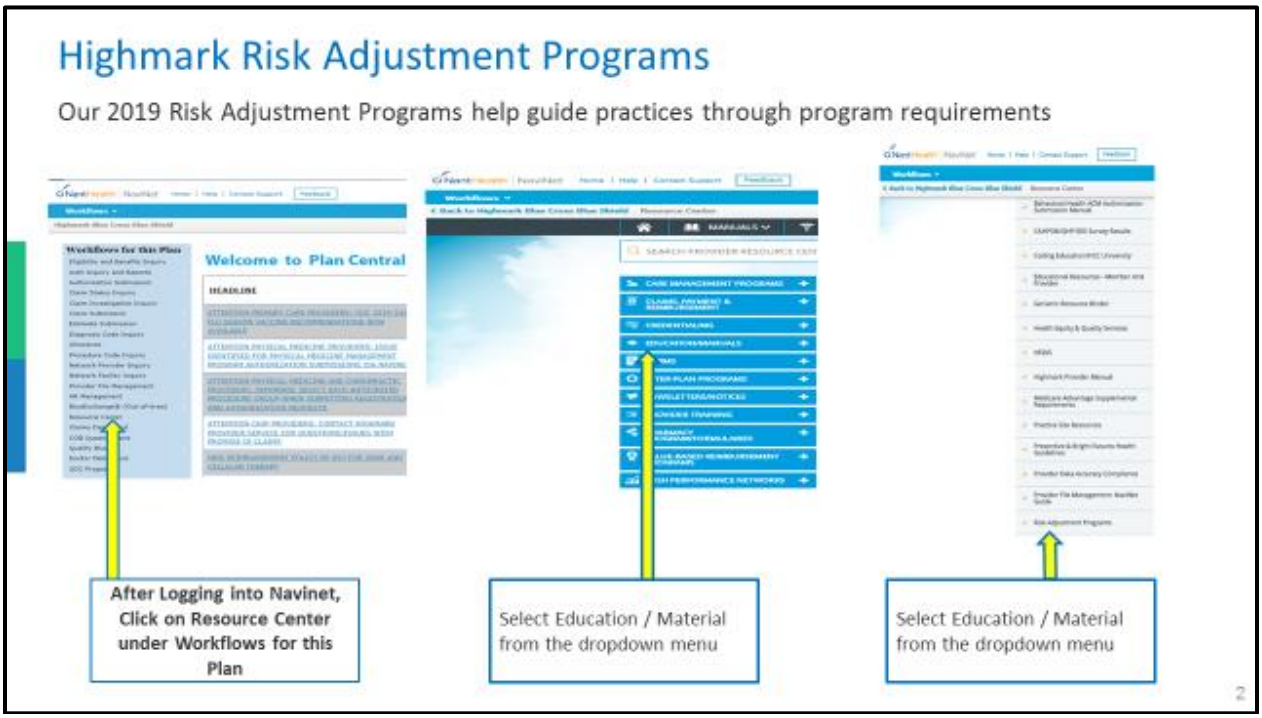
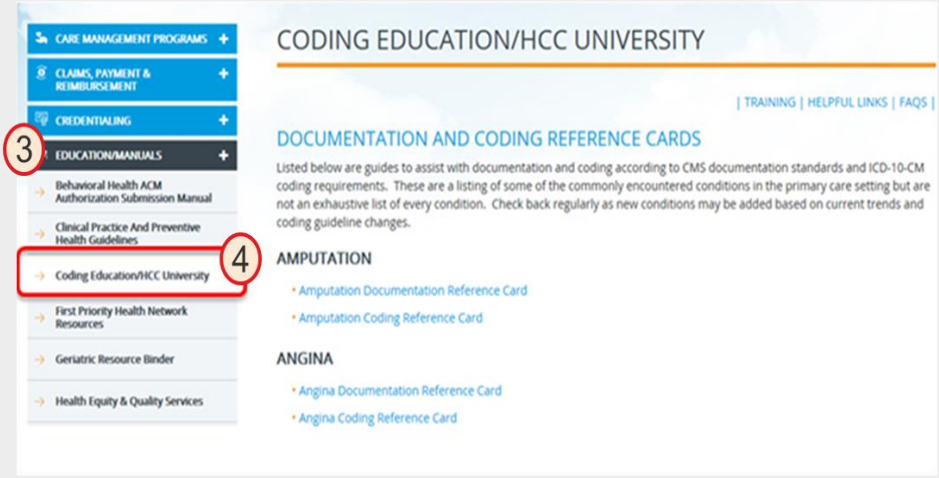
# Appendix C: Revenue Program Management Coding and Training Materials



# Appendix C: Revenue Program Management Coding and Training Materials

HCC University is a provider coding resource on NaviNet. It contains guides to assist with documentation and coding according to CMS documentation standards and ICD-10-CM coding requirements.




1. Log into **NaviNet**
2. Navigate to the **Provider Resource Center**
3. Select "**Education/Manuals**" from the menu bar to expand the selection
4. Select "**Coding Education/HCC University**" to open the page with corresponding resources