First Quarter 2017

MedStar Select/Medicare Choice Provider Newsletter

MedStar Medicare Choice Risk Adjustment Factor (RAF) Program

MedStar Medicare Choice is committed to the ongoing health and wellness of our Medicare members. We know that as our partner, you are the key to optimizing health outcomes and improving the member experience.

We encourage participating providers to conduct an annual comprehensive exam and patient assessment for each of our MedStar Medicare Choice members in exchange for reimbursement which recognizes the enhanced level of time and effort that you and your practice invest. MedStar Medicare Choice will provide you with patient data indicating specific patients on your panel that are due for this care via pre-populated forms as well as a member roster.

Remember, capturing appropriate diagnosis codes through the RAF program drives improved patient care and clinical quality.

(continued on next page)

Knowledge and Compassion
Focused on You

(continued from page 1)

Why RAF is important:

- Enhances physicians' understanding of their patient population's chronic conditions
- Allows for an accurate account of the population's clinical profile, including conditions treated by specialists, complications and comorbidities
- Helps identify previously undocumented suspect medical conditions through integration of patient data
- Encourages outreach to patients without regular visits to their primary care physician
- Providers fair payment for accurate treatment

Enhanced Payment

You can receive a $200 payment for completing the following:

- Conduct a face-to-face visit with a MedStar Medicare Choice member.
- Using the Patient Assessment Form (PAF), check 'confirm' next to all conditions that are currently affecting the patient's care.
- During the face-to-face visit, discuss all 'confirmed' conditions with the member, making sure to document them in the medical record. Make sure to document a treatment plan for each condition.
- Submit the completed PAF worksheet via fax to **202-379-7826** or scan/email to **rafworksheet@evolenthealth.com**.
- Bill the office visit with CPT Code 99429 and add the ICD-10 diagnosis codes for all 'confirmed' conditions that were addressed during the visit.

Note: Copayment, coinsurance and deductible amounts, if any, for MedStar Medicare Choice members are waived for these visits.

Want to learn more about the RAF Program?

Receive 0.5 CME credits for viewing the RAF education video at **MedStarProviderNetwork.org**, then click on the Annual Required Training.

Have further questions about RAF or need your 2017 worksheets?

Call us at: **443-201-1287** or **443-201-1226**.

HEDIS Season

Every year, MedStar Health is required to report HEDIS data to the National Committee for Quality Assurance (NCQA). This reporting is also mandated by the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage plans. MedStar has contracted with Datafied to retrieve any medical records necessary for HEDIS. Therefore, in the upcoming months, you may be receiving a call from Datafied requesting MedStar member's records.

What is HEDIS?

The Healthcare Effectiveness Data and Information Set® (HEDIS) is used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. It allows the comparison of health plans in the following key areas of measurement: quality of care, access to care and member satisfaction with the health plan and providers.

1. When will the collection of these records occur?

Medical record reviews can occur from February through May 15, 2017.

2. Are all MedStar Health member's records needed?

No, records are only needed for a random subset of MedStar Health associates who are part of MedStar Medicare Choice, MedStar Medicare Choice Dual Advantage and MedStar Medicare Choice Care Advantage.

3. Does the Health Insurance Portability and Accountability Act (HIPAA) permit me to release records to Datafied for HEDIS data collection?

Yes. As a MedStar Health contracted provider, you are permitted to disclose protected health information (PHI) to Datafied, our contracted medical record reviewer. A signed consent from the member is not required under the HIPAA privacy rule for you to release the requested information.

4. Is my participation in HEDIS data collection mandatory?

Yes. Network participants are contractually required to provide medical record information "for the purpose of quality assurance," and this includes HEDIS.

5. What is my office's responsibility regarding HEDIS data collection?

You and your office staff are responsible for replying to the request from Datafied in a timely manner and providing access to the requested records either by fax, mail, remote access to the EMR or on-site review.

Surveys to Our Members

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

In March through April 2017, some MedStar Medicare Choice Health Plan members may receive a member experience survey called the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey from an approved survey firm for the Centers for Medicare & Medicaid Services (CMS). The CAHPS survey asks members about their experiences with and ratings of healthcare providers and health plans, including hospitals, home health agencies, doctors, health plans and drug plans.

Not all members will be surveyed, and those receiving the surveys are randomly selected. CMS develops, implements and administers member experience surveys. The CAHPS survey makes up a large portion of the Medicare Star rating. The survey is a way to assess member experience with their health plan and their providers.

Answers remain anonymous, and the feedback is used to identify ways to improve the member experience. MedStar Medicare Choice Health Plans does not receive the names of those surveyed and does not know how a person replied.

MedStar Medicare Choice Health Plan uses the overall results to target quality improvement activities and monitor health plan performance.

Health Outcome Survey (HOS)

In April 2017, a random sample of MedStar Medicare Choice members may also receive the Health Outcome Survey (HOS). The HOS is made up of 68 questions which seeks to gather valid, reliable and clinically meaningful health status data in the Medicare Advantage population. The HOS is conducted each year to gather a new baseline cohort. Two years later, the same respondents are surveyed again as the follow up measurement.

The following questions from the HOS are factored into a health plan's Star rating:

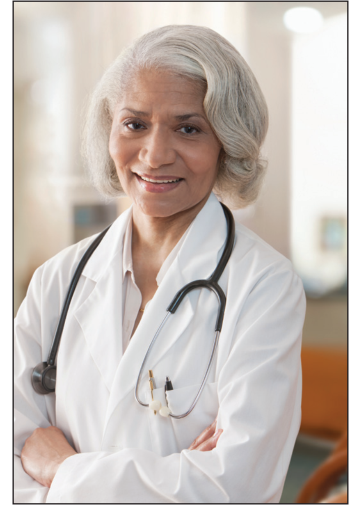
- Improving or Maintaining Physical Health
- Improving or Maintaining Mental Health Functional Health

Please encourage your patients to complete these surveys.

Avoid Timely Filing Denials

A common denial is for timely filing; however, this can be avoidable. A claim must be received for MedStar Select or MedStar Medicare Choice within 180 days from the date of service. Claims submitted after 180 days will be deemed untimely and will not be paid. Members cannot be balanced billed for services, when a provider receives a timely filing denial. The only exception is for COB claims. For example, if a member has both Medicare (primary carrier) and MedStar Select (secondary carrier), the claim must be filed with MedStar Select as the secondary carrier within 18 months from the date of the Medicare explanation of benefits (EOB) to be considered timely.

It is always required that the provider submit an EOB with the claim once they receive it. When a claim is submitted, please retain a copy of the EOB as your proof of timely filing since this is the only acceptable proof that a claim has been filed in a timely manner. Billing system printouts are not acceptable proof that a claim was filed in a timely manner. Submitting claims as soon as possible allows providers additional time to submit corrected new claims within the required 180-day period.



For claims inquiries, including verifying receipt of a claim or inquiring about the status of a claim, call Provider Services at **855-222-1042** or log on to the provider portal at **MedStarProviderNetwork.org**. For Provider Online login requests, call Provider Services at **855-222-1042** or email **provider_support@togetherforyourhealth.com**.

Contact Us

We are here to help. Please reference the below list of numbers if you have any questions or concerns. In some cases, there are separate numbers for MedStar Medicare Choice and MedStar Select.

Member Services

MedStar Medicare Choice
Monday through Friday, 8 a.m. to 8 p.m.
Saturday, 8 a.m. to 3 p.m.
855-222-1041 **PHONE**

MedStar Select (My Health Service Line)
Monday through Friday, 7 a.m. to 7 p.m.
Saturday, 8 a.m. to 3 p.m.
855-242-4872 **PHONE**

Care Management

MedStar Medicare Choice
Monday through Friday, 8:30 a.m. to 5 p.m.
866-823-1701 **PHONE**

MedStar Select (My Health Care Management)
888-959-4033 **PHONE**

Medical Management/Prior Authorization

MedStar Medicare Choice and MedStar Select
Monday through Friday, 8:30 a.m. to 5 p.m.
855-242-4875 **PHONE**

Provider Services
(For claims, eligibility, website access, etc.)

MedStar Medicare Choice and MedStar Select
Monday through Friday, 8:30 a.m. to 5 p.m.
855-222-1042 **PHONE**

Provider Relations
(For credentialing/recredentialing or practice additions/terminations/address changes)

MedStar Medicare Choice and MedStar Select
msfcproviderrelations2@medstar.net **EMAIL**
For Maryland Providers: Monday through Friday, 8:30 a.m. to 5 p.m.
800-905-1722, option 5 **PHONE**

For DC Providers: Monday through Friday, 8:00 a.m. to 5:30 p.m.
855-210-6203, option 5 **PHONE**

To verify member eligibility, access the provider website at **MedStarProviderNetwork.org** or call Provider Services at **855-222-1042**.

MedStar Select Pharmacy Benefits

MedStar Select members are covered under a prescription benefit plan administered by Evolent and CVS/Caremark.

As a way to help manage healthcare costs, authorize generic substitution whenever possible. Consider prescribing a brand name on the Preferred Drug list at **MedStarProviderNetwork.org** if you believe a brand name product is necessary. Certain drugs are covered under the medical benefit and not the pharmacy benefit and may require prior authorization. In these situations, the drugs would be administered in your office instead of the member picking the drug up at the pharmacy. Please reference the Prior Authorization list on **MedStarProviderNetwork.org** or call Provider Services at **855-266-0712**.

Please note:

- Generics should be considered the first line of prescribing.
- The drug list represents a summary of prescription coverage; it is not inclusive and does not guarantee coverage.
- The member's prescription benefit plan may have different copay for specific products on the list.
- Unless specifically indicated, drug list products will include all dosage forms.
- Log in to **Caremark.com** to check coverage and copay information for a specific medicine.

Where can MedStar Select members get their vaccines?

Any in-network pharmacy can administer and bill for BOTH the cost of the drug and the administration of the drug through the member's pharmacy benefit. The following seasonal and nonseasonal vaccines are available to MedStar Select members at no additional cost at any participating in-network pharmacy.

Seasonal Vaccines:

- Injectable Flu Vaccine (Trivalent and Quadrivalent)
- Injectable High-Dose Vaccine
- Intranasal Flu Vaccine

Nonseasonal Vaccines:

- Diptheria
- Diptheria Toxoids
- Haemophilus B
- Hepatitis A
- Hepatitis B
- Human Papillomavirus (Gardasil®)
- Inactivated Poliovirus
- Measles
- Meningiococcal
- Mumps
- Pertussis
- Pneumonia
- Rotavirus
- Rubella
- Tetanus
- Varicella
- Zoster (Zostavax®)

MedStar Medicare Choice Pharmacy Benefits

The pharmacy benefits manager for MedStar Medicare Choice is Evolent Health. A directory of participating pharmacies, the formulary, and prior authorization forms are available at **MedStarProviderNetwork.org**. Please utilize these resources to determine if the prescribed drug is on the current formulary, if a prior authorization is required, there are quantity limits, or if step therapy is required. If your patient must take a nonformulary medication, an exception may be available. To request an exception, complete the nonformulary exception form, posted on **MedStarProviderNetwork.org** under Pharmacy Prior Authorization forms. Please remember, if approved, the medication will be tiered as nonpreferred and may still incur significant costs for the patient. Please call Evolent Health at **855-266-0712** with questions.

Where can MedStar Medicare Choice Members get their Vaccines?

Medicare beneficiaries must receive most of their vaccinations from a pharmacist at a pharmacy (mandated by the Medicare Part D benefit). If a Medicare beneficiary receives a vaccine that is covered under the Medicare Part D benefit in a physician's office rather than at a pharmacy, the member is responsible for the cost of the drug and the administration of the drug. In this instance, the Medicare beneficiary would have to submit for reimbursement from their Medicare Part D plan administrator. Exception: influenza, pneumonia and tetanus (following an injury) are covered through the member's medical benefit and can be administered at and billed by a pharmacy, a physician's office or an Emergency department.

Helping Your MedStar Medicare Choice Patients Afford Their Diabetic Care

For many of your patients, caring for their diabetes is not only an emotional challenge, but also a financial challenge. For some, this financial burden has led to medication adherence issues and other complications. If your patient is still struggling financially, patient assistant programs may be available. These programs are typically offered for brand-only medications and are sponsored by the drug manufacturer. The following two websites can help in determining your patient's eligibility for assistance programs: **NeedyMeds.org** and **Medicare.gov/Pharmaceutical-Assistance-Program**.

Low-income Medicare patients may also contact the Social Security Administration to determine if they qualify for Medicare Extra Help (low income subsidy), which may reduce their prescription costs. More information can be found at **SocialSecurity.gov/ExtraHelp** or by calling **800-772-1213**. When prescribing for diabetic testing supplies, the covered manufacturers are Lifescan (OneTouch products) and Bayer (Contour products). The quantity limit for blood glucose test strips is 150 strips per 30 days. If more frequent testing is required, a quantity limit exception may be applied. Please complete the prior authorization form found on **MedStarProviderNetwork.org**.

Remember, all Full LICS members can receive a 90-day supply of medication for the cost of a 30-day supply. This includes all DSNPs. CSNPs would be if they have met full LICS.

Care Advising: Helping You Care for High-Risk Patients at $0 cost

Care advising offers personalized, one-on-one support to your patients who need extra help managing their health. Care advising uses evidence-based programs and proactive care delivery to help improve patient outcomes and reduce costs.

Informed by the patient's primary care team, care advising serves as a complement of care outside of the office setting. Care advisors, who are registered nurses, work with patients across a continuum of care management programs, including:

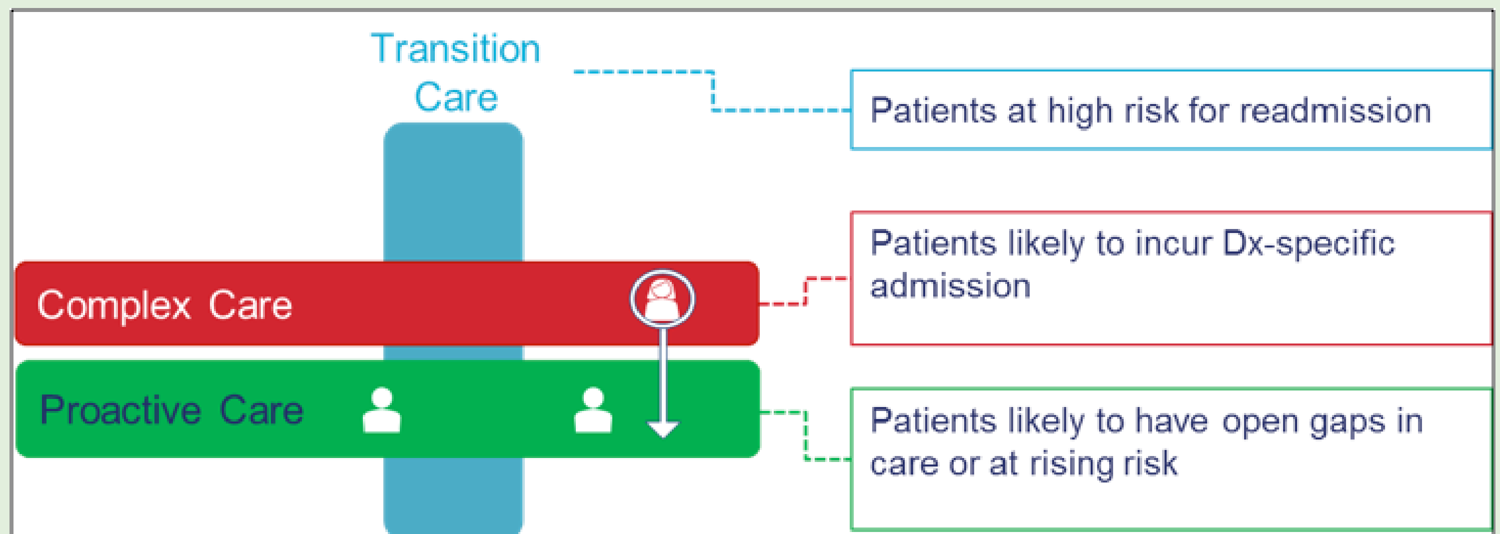
- Transition care, which focuses on patients who are at high risk for hospital readmissions
- Complex care, which focuses on patients likely to incur a disease-specific admission
- Proactive care, which focuses on patients who are likely to have open gaps in care or are at rising risk

What Care Advisors Do:

- Help patients identify their personal health goals and create a care plan to achieve those goals
- Work closely with you to review your patient's care plan and monitor progress
- Regularly check on patients' progress, care plan adherence, and assess ongoing needs
- Help patients get doctor visits and screenings scheduled
- Attend doctor visits where appropriate
- Find appropriate support services close to patients' home or work
- Help with medication questions, food choices and social needs

Working on behalf of MedStar Health and the patient's primary care doctor, care advisors will engage eligible patients by phone or in person. Patients who choose to participate will work with the same care advisors until their goals are achieved, which gives the care advisors greater opportunity to get to know each patient's unique healthcare needs.

At this time, MedStar Medicare Choice (Medicare Advantage) members, MedStar ACO beneficiaries, and MedStar employees and their dependents covered by CareFirst or MedStar Select may be eligible for care advising services. Only those individuals who are identified as in need of additional support—through physician referral and a comprehensive assessment of health data—will be contacted to participate. If you believe you have a patient who may be appropriate for care advising services, contact our care advising line: **888-959-4033**.



Tips for Ensuring Patient Privacy

HIPAA/HITECH rules are federal laws that regulate what can and cannot be done with patient information. Personal health information (PHI), also referred to as protected health information, generally refers to demographic information, medical history, test and laboratory results, insurance information and other data that a healthcare professional collects to identify an individual and determine appropriate care.

PHI is any information about health status, provision of health care or payment for health care that is created or collected and can be linked to a specific individual. Electronic protected health information (ePHI) is any electronic form of PHI, including data stored on computer hard drives, file servers, data storage tapes and CDs, as well as data transmitted electronically. A few simple steps can help protect PHI and ePHI daily. These tips include:

- Do not leave patient information in areas where it can be viewed by unauthorized personnel.
- Sign-in sheets should not state the reason for the patient's medical appointment.
- Face sheets should be turned toward the wall if patient charts are outside of an examination room.
- Keep confidential conversations at a low level.
- Leave minimum information regarding appointments on patients' voicemails, emails or text messages.
- Computers and workstations should be in an area that minimizes accidental and nonauthorized viewing of patient information.
- Assign strong passwords to computer systems.
- Do not share user IDs or passwords, or post passwords in or around workstations where they can be viewed easily by others.
- Always log off of computers and workstations when leaving work for a long period of time or lock computers when away from the workstation.
- Add password-protected to personal workstations.
- Protect electronically transmitted PHI through encryption and password protect electronic patient information.
- Save PHI data to the appropriate locations and in the appropriate manner so the data is backed up regularly.
- Properly dispose of any documents or papers containing PHI in shredders or special destruction boxes.

You can visit the U.S. Department of Health and Human Services' website at **HHS.gov** for more information regarding HIPAA rules.

Tips and Additional Discussions to Improve Your Patients' Medication Adherence Rates

Each visit with your patient should consist of a comprehensive review of medications. Be sure to discuss any concerns your patients may have so you can better assist them with cost, side effects or other health improvement tactics.

If your patients are having trouble adhering to their medications, consider the following reasons:

- Cost
- Access
- Side effects
- Forgetfulness

As their provider, you may be able to help by considering the following:

- Why they have chosen to stop taking their medications?
- Are there alternatives available to cut down costs and/or minimize side effects?
- Have they been provided with medication-related education?
- Do they have access to a pharmacy that delivers?
- Are they using a pillbox to organize their medications?
- Have they been encouraged to relate pill-taking to daily activity?
- Are they interested in enrolling in an auto-refill program offered by mail order or a local pharmacy?

Remember, all Full LICS members can receive a 90-day supply of medication for the cost of a 30-day supply. This includes all DSNPs. CSNPs would be if they have met full LICS.

If your patients have questions in between visits, encourage them to contact your office.

Reporting Fraud, Waste and Abuse to the Health Plan

MedStar Select and MedStar Medicare Choice have policies and procedures in place to monitor and report on fraud, waste and abuse. This includes monitoring claims for accuracy by ensuring coding reflects services that were provided, monitoring medical records to confirm that the documentation in the chart supports the services rendered, performing regular internal and external audits and taking action when a problem has been identified. Some common examples of fraud and abuse include:

- Billing for services and/or medical equipment that were never provided to the member
- Billing more than once for the same service
- Dispensing generic drugs and billing for brand-name drugs
- Falsifying records
- Performing and/or billing for inappropriate or unnecessary services

Information reported via phone, mail, website or email may all be done anonymously. The website contains additional information on reporting fraud and abuse.

If overpayments related to fraudulent or abusive billing have been identified, the health plan reserves the right to retract those payments made to providers.

Reporting by Phone

MedStar Select and MedStar Medicare Choice health plans have an established hotline for reporting suspected fraud, waste and abuse concerns committed by any entity providing services to a member. You may contact the MedStar Medicare Choice Compliance Director, Catherine Kajubi, at **202-243-5419**. In addition, the MedStar Health Integrity Hotline is available 24 hours a day, seven days a week. Callers have the option to leave a voicemail and/or report anonymously.

MedStar Health Integrity Hotline: **877-811-3411**

Reporting by Mail

Suspected fraud, waste and abuse may also be reported by mail. Please mark the outside of the envelope "confidential" or "personal" and mail to:

MedStar Medicare Choice and/or MedStar Select
5233 King Ave, Suite 400
Baltimore, MD 21237
Attn: Cathy Kajubi

Additional Resources for MedStar Medicare Choice

Suspected fraud, waste and abuse concerns can also be reported directly to the Centers for Medicare and Medicaid Services (CMS) as it pertains to MedStar Medicare Choice. CMS has an established hotline to report suspected fraud, waste and abuse committed by any person or entity providing services to Medicare beneficiaries. The Centers for Medicare and Medicaid Services (CMS) hotline is available Monday through Friday from 8:30 a.m. to 3:30 p.m. Callers may remain anonymous. Callers may call after hours and leave a voicemail if preferred. CMS Hotline: **800-HHS-TIPS** (800-447-8477)

MedStar Medicare Choice: Equal Access to Appointments

There are several federal laws that protect Medicare recipients from discrimination. The national law that protects Medicare recipients from being denied services because of race, color or national origin is Title VI of the Civil Rights Act of 1964. Title VI laws are enforced by the Office for Civil Rights (OCR). Other laws enforced by the OCR include the Age Discrimination Act of 1975, the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act of 1990. As described within these laws, Medicare recipients:

- Must not be discriminated against in the provision of healthcare services
- Are entitled to receive care without regard to race, age, gender, color, sexual orientation, national origin, religion, physical or mental disability or type of illness/condition

An example of discrimination includes offering fewer hours to Medicare recipients than to commercial members, and/or designating different office hours for Medicare patients. Providers must provide the same access standards for all patients, regardless of the payor. Services may not be denied or performed in a different manner and members may not be subjected to segregation or separate treatment based on these factors. Please report equal access or discrimination concerns regarding MedStar Medicare Choice members to our Provider Relations department at **800-905-1722**, option 5. More information regarding these laws can be found at **HHS.gov/OCR** or you can call the U.S. Department of Health and Human Services Office for Civil Rights hotline at **800-368-1019**.

MedStar Select and MedStar Medicare Choice Helpful Hints

Below are quick references and helpful reminders for your practice. If you have additional questions or concerns, please contact Provider Services at **855-242-1042**.

- The complete list of services requiring medical prior authorization is listed on **MedStarProviderNetwork.org**. In addition, the prior authorization process and forms can be found in the medical policies folder on **MedStarProviderNetwork.org**. For pharmacy prior authorizations, you can also refer to the pharmacy section in the provider manual, which also describes the process for prior authorizations for specialty pharmacy and drugs covered under the medical benefit.
- Provider Referrals
  - MedStar Medicare Choice members do not have out of network benefits, please refer members to MedStar Medicare Choice providers located in the provider directory.
  - MedStar Select members do have out of network benefits at a higher cost share. For the lowest out of pocket cost, please refer members to MedStar Select providers located in the provider directory. All out of network services require prior authorization.
  - If you have questions, prior to referring providers, please contact Provider Services at **855-242-1042**.
- Claim submission from the date of provider transmission could take up to 30 days. Providers can inquire on the provider portal at **MedStarProviderNetwork.org** for the status of a claim.
- Medical Policy updates: Three medical payment policies were recently updated and go into effect April 15, 2017:
  - MP.138.MH-Oral Maxillofacial Prosthesis
  - PA.137.MH-Imaging Demetia
  - PA.135.MH-Artificial Disc Replacement

MedStar Medicare Choice Vision Benefit

MedStar Medicare Choice members have their vision benefit through Superior Vision. There is a $0 copay for one routine eye exam per year and $100 allowance toward the cost of one pair of glasses (frames and lenses) or contact lenses every year.

Diabetes Eye Exam

Diabetes retinopathy is the leading cause of blindness in American Adults. Encourage your members who have diabetes to have their annual dilated eye exam. The diabetes eye exam is of $0 cost to the member, which applies to ophthalmologists as well.

If you have any questions about the Superior Vision care benefit or for help finding an in-network vision provider, please call Superior Vision anytime, 24 hours a day, seven days a week, at **800-766-4393** (TTY 711).

5233 King Ave., Suite 400
Baltimore, MD 21237
800-905-1722 **PHONE**
MedStarProviderNetwork.com

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The MedStar Select and MedStar Medicare Choice Newsletter is a publication of MedStar Health. Submit new items for the next issue to MedStar Family Choice Provider Relations at **mfc-providerrelations2@medstar.net**.

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MedStar Franklin Square Medical Center
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MedStar Good Samaritan Hospital
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