Blue Cross Blue Shield of Rhode Island

2019 BCBSRI Advanced Primary Care Policies

CTC-RI Practice Reporting & Practice Transformation Meeting
May 22, 2019

Nurse Care Manager (NCM)/Care Coordinator (CC) Responsibilities

- Provide primary case management services for identified high risk members, including assessment, care plan development, and member education;
- Act as a liaison between members, providers, community resources, and payers;
- Facilitate effective transitions of care through timely communication of necessary information for patient care and discharge planning;
- Coordinate, directly or with the clinical team, community resources for patients and caregivers;
- Conduct medication reconciliation as appropriate and communicate any needed adjustments to care team and providers;
- Support clinical gap-in-care closure;
- Document member engagement for high risk engagement reporting and care plan creation;
- Participate in patient-engagement training in accordance with Office of Health Insurance Commissioner (OHIC) guidelines. In addition, all NCMs/CCs are eligible to complete BCBSRI Care Fundamentals training for practices recognized as a PCMH;
- Support full population management across attributed patient panel, to include emerging risk and wellness promotion initiatives (e.g. tobacco cessation, chronic condition management, exercise promotion)

Patient Engagement Requirements

- Practices will be measured on their ability to complete transitions of care (TRC) interventions for patients post-discharge from a hospital or SNF

- 2019 will be a baseline measurement year to determine TRC performance targets moving forward

- Practices are expected to manage their identified high risk members at current engagement rates, but will no longer be required to submit quarterly engagement reports to BCBSRI
  - BCBSRI may request information on the engagement of high risk and high cost claimants in response to NCQA and/or employer/business needs

Transitions of Care

The TRC measure assesses the percentage of discharges for members age 18 or older who had each of four reported indicators during the measurement year. This measure applies to Medicare members only but the practice should follow the same workflow for all patients.

TRC services should be provided after the patient is discharged from one of these settings:

- Inpatient acute care hospital
- Inpatient psychiatric hospital
- Long-term care Hospital
- Skilled nursing facility (SNF)
- Inpatient rehabilitation facility

1. **Notification of Inpatient Admission-** Documentation must include evidence of receipt of notification of inpatient admission on the day of admission or the following day.

WHAT YOU NEED TO DO: The communication from the facility must be received on the day of admission or the following day. The notification should be scanned into the medical record with the date it was received.

2. **Receipt of Discharge Information-** Documentation of receipt of discharge information on the day of discharge or the following day**.**

WHAT YOU NEED TO DO: The communication from the facility must be received on the day of discharge or the following day. The notification should be scanned into the medical record with the date it was received. Be sure the following information is included:

- The practitioner responsible for the member's care during the inpatient stay.
- Procedures or treatment provided.
- Diagnoses at discharge.
- Current medication list (including allergies).
- Testing results, or documentation of pending tests or no tests pending.
- Instructions for patient care.

3. **Patient Engagement After Inpatient Discharge-** Documentation of patient engagement (e.g., office visits, visits to the home, or telehealth) provided within 30 days after discharge. Do not include patient engagement that occurs on the date of discharge.

WHAT YOU NEED TO DO: PCP should call the patient at notification of discharge to schedule an appointment. Ideally the patient should be seen within 14 days, however, they must be seen within 30 days of discharge.

4. **Medication Reconciliation Post-Discharge-** Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse, as documented through either administrative data or medical record review on the date of discharge through 30 days after discharge (31 total days).

WHAT YOU NEED TO DO: The medication reconciliation should be completed in person or telephonically within 30 days after discharge. Documentation in the medical record must include evidence of medication reconciliation and the date when it was performed.

Workflow for Transitions of Care

This workflow will help successfully implement TRC in your practice.

1. 

Patient admitted.
Hospital notifies PCP of admission on the day of admission or the following day.

2. 

PCP receives notification **and enters it into medical record with the date received.**

3. 

Patient discharged home.
Hospital notifies PCP of discharge on the day of discharge or the following day.

4. 

PCP receives notification **and enters it into medical record with the date received.**

PCP calls patient within 2 days of discharge to **schedule an appointment.**

Complete **encounter** and complete **medication reconciliation within 30 days of discharge.**

TRC Coding for Medicare Members

Face-to-face Encounter	Visit Codes
Patient seen within **7** days of discharge	99496 – med rec included
Patient seen within **14** days of discharge	99495 – med rec included
Patient seen within **30** days of discharge	99201-99215 & 1111F with $0.00 charge

Tips for your practice

Having trouble getting admission and discharge notifications from the hospitals? Work with the hospitals to figure out the most efficient way to communicate for both parties. Reach out to BCBSRI if you need assistance.
A telemedicine phone call is sometimes sufficient for the encounter. The medication reconciliation can also be completed telephonically.
If you are using a received stamp, make sure the date on the stamp matches the date the notification was actually received from the hospital. Any other later dates on the notification will result in noncompliance.

PQIP medical record submissions may be emailed to PQIP@bcbsri.org or faxed to Quality Analytics at (401) 459-5567. If faxing, please write PQIP on the cover sheet. If you have questions or need clarification, email QualityHEDIS@bcbsri.org or call (401)459-1005.

Provider Access Reporting

All practices (or systems of care on behalf of practices) will be required to submit quarterly access reports.

Report Details:

- **New patient access**: All active providers, indication of accepting new patients, and time to next new patient appointment if applicable
- **Existing patient access**: All active providers, time to 3rd next available well-visit and sick-visit appointment for existing patients

Due Dates:

- January 20, April 20, July 20, October 20

Quality Improvement

In support of high quality healthcare measurement, PCMH and SOC practices participate in applicable PCP quality improvement programs

These may include:

- Consumer Assessment of Healthcare Providers and Systems (CAHPS),
  - including providing patient level information as requested, educating patients on the survey process and timeframes, and encouraging participation;
- Annual participation in the PCP Quality Incentive Program (PQIP), to promote clinical gap closure
- Additional quality reporting as required by an active contract
- OHIC required quality improvement initiatives and reporting

Blue Cross Blue Shield of Rhode Island

Please direct any questions to pcmh@bcbsri.org