South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross Blue Shield Association.

QUALITY IMPROVEMENT

DISCLAIMER

The information included is general and in no event should be deemed as a promise or guarantee of payment. We do not assume and hereby disclaim any liability for loss caused by errors or omissions in preparation and editing of this publication.

AGENDA

- National Committee for Quality Assurance (NCQA®)
- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Requests for Information and Compliance
- Lines of Business Breakouts
- Quality Navigator Program
- Risk Adjustment Data Validation (RADV)
- Key Takeaways

NATIONAL COMMITTEE FOR QUALITY ASSURANCE

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA®)

What is the National Committee for Quality Assurance (NCQA)?

- NCQA is a private organization dedicated to improving healthcare quality by developing quality standards and performance measures.
- Healthcare Effectiveness Data and Information Set (HEDIS®) coordination
- Provider involvement

WHAT NCQA MEANS TO PROVIDERS

Contracts
Bonuses
Incentives

Reporting
data back to
the plan

Patient
Safety

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS®)

What is Healthcare Effectiveness Data and Information Set (HEDIS)?

- HEDIS is used to track trends in population health.

What entities utilize HEDIS data?

- NCQA®
- Members
- Centers for Medicare and Medicaid Services (CMS)
  - Quality Rating System for the ACA/Exchange products
  - Medicare Advantage
- Federal Employee Program (FEP)

HEDIS SEASONS

HEDIS Seasons

- Types of HEDIS seasons include:
  - Retrospective (also referred to as Retro or Hybrid)
  - Prospective (also referred to as Year-Round)
- Each season is based on when the data is being gathered related to the measurement year.

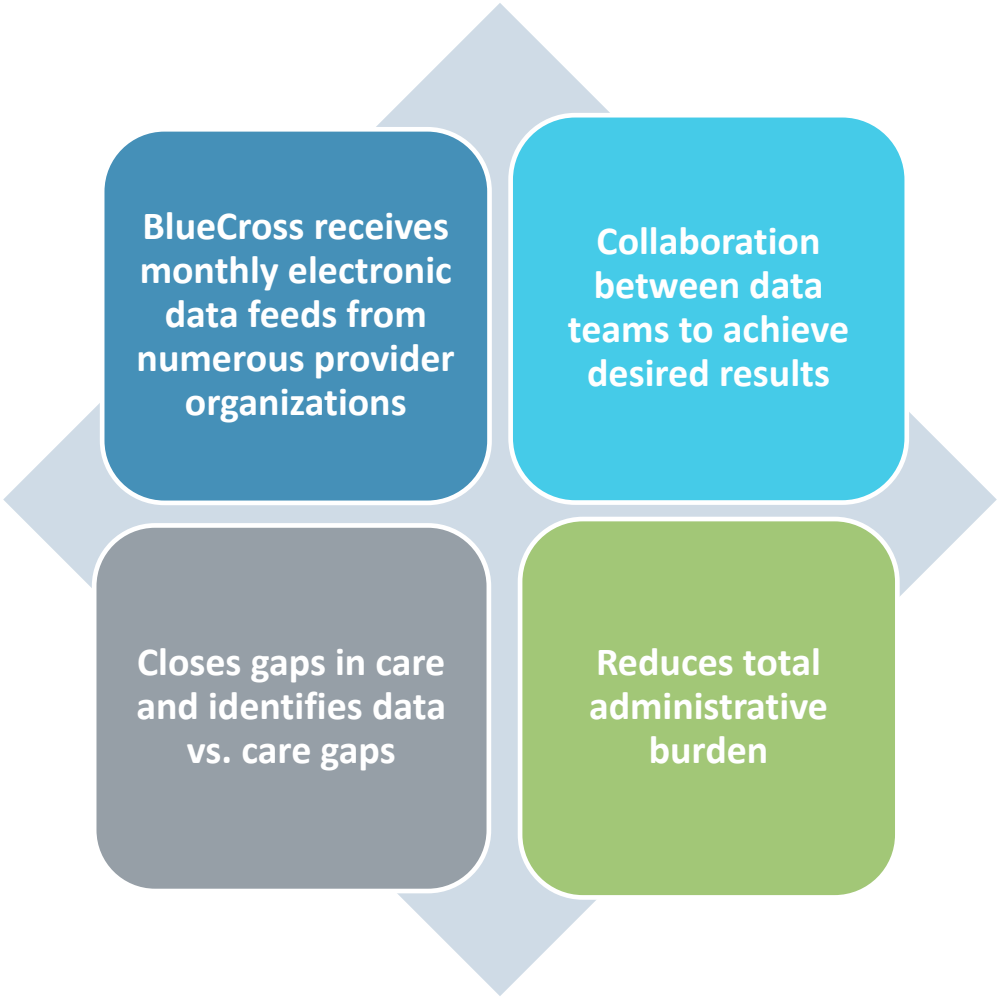
RETROSPECTIVE SEASON

- Also referred to as Retro or Hybrid season or HEDIS Production
- Looks at the care given or due in the prior year (measurement year)
- Runs from January to May of the year following the measurement year
- Members are chosen by NCQA
- All requested member documentation is based on the selected HEDIS measure

PROSPECTIVE SEASON

- Also referred to as Year-Round
- Continuously monitors rates in real-time
- Runs from January 1st to December 31st of the current/measurement year
- Total membership rates
- Additional options for compliance
  - Claims
  - Data transfer
  - Medical records
  - Compliance forms

ELECTRONIC DATA TRANSFER



REMOTE ACCESS

BlueCross currently has many providers that allow remote access to their EMR

Assigned navigator can locate and retrieve records from the EMR remotely

Helps to reduces provider burden

REQUESTS FOR INFORMATION

MEDICAL RECORDS REQUESTS

Medical Records Request

Prospective/ Year-Round Season

Medical Records Request

Retrospective Review/HEDIS Hybrid Season

REQUESTS FOR MEDICAL RECORDS

How are requests sent?

- Sent via email, fax or mail
- Can be avoided by giving remote access to EMR
  - Email NAVIGATOR@bcbssc.com

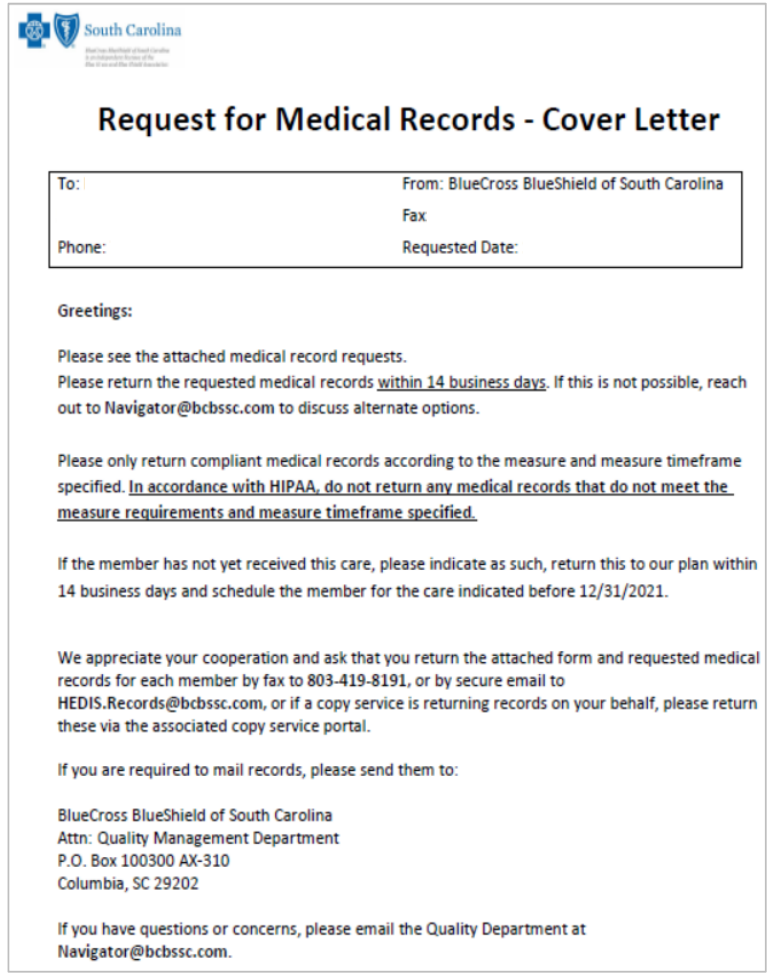
How are requests created?

- Claims

How are members attributed?

- Claims data

Note: You will not receive medical records requests for compliance that was already received during Prospective HEDIS.



South Carolina

Request for Medical Records - Cover Letter

To:	From: BlueCross BlueShield of South Carolina
	Fax
Phone:	Requested Date:

Greetings:

Please see the attached medical record requests.
Please return the requested medical records within 14 business days. If this is not possible, reach out to Navigator@bcbssc.com to discuss alternate options.

Please only return compliant medical records according to the measure and measure timeframe specified. In accordance with HIPAA, do not return any medical records that do not meet the measure requirements and measure timeframe specified.

If the member has not yet received this care, please indicate as such, return this to our plan within 14 business days and schedule the member for the care indicated before 12/31/2021.

We appreciate your cooperation and ask that you return the attached form and requested medical records for each member by fax to 803-419-8191, or by secure email to HEDIS.Records@bcbssc.com, or if a copy service is returning records on your behalf, please return these via the associated copy service portal.

If you are required to mail records, please send them to:

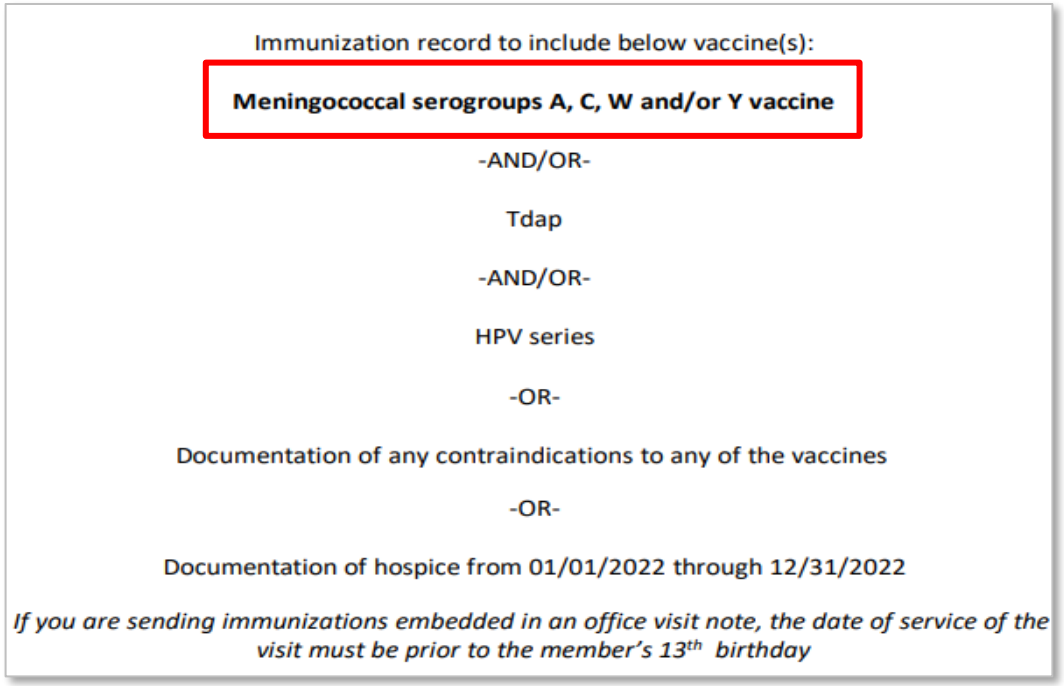
BlueCross BlueShield of South Carolina
Attn: Quality Management Department
P.O. Box 100300 AX-310
Columbia, SC 29202

If you have questions or concerns, please email the Quality Department at Navigator@bcbssc.com.

WHAT TO RETURN

- Providers are required to return the requested information in **BOLD** if there are multiple sub-measures on a page.

Example



Immunization record to include below vaccine(s):

Meningococcal serogroups A, C, W and/or Y vaccine

-AND/OR-

Tdap

-AND/OR-

HPV series

-OR-

Documentation of any contraindications to any of the vaccines

-OR-

Documentation of hospice from 01/01/2022 through 12/31/2022

If you are sending immunizations embedded in an office visit note, the date of service of the visit must be prior to the member's 13th birthday

WHAT TO DO IF YOU CANNOT LOCATE THE PATIENT

- Check the appropriate box and return the letter via fax, email or mail.

Please check the appropriate box:

☐ Unable to locate patient in medical records

☐ Medical Record Attached, please return via one of the following methods:

FAX: 803-419-8191
EMAIL: HEDIS.Records@bcbssc.com
MAIL: BlueCross BlueShield of South Carolina, Attn: Quality Management Department, P.O. Box 100300 AX-310, Columbia, SC 29202

☐ No medical records with requested information during the time frame specified

LINES OF BUSINESS

LINES OF BUSINESS

- **Healthy Blue (Medicaid)**

- **Health Insurance Exchange (HIX or ACA)**

Independent licensees of the Blue Cross Blue Shield Association.

- **Federal Employee Program (FEP)**

HEALTH INSURANCE EXCHANGE

- The Exchange Line of Business (LOB) covers health plans on the insurance marketplace.
- Used by more than 90 percent of the nation's health plans, employers and regulators.
- The current population has over 276,000 members.
- Measures Clinical, customer satisfaction and patient quality.
- CMS provides guidance to health plans for the Exchange LOB via the Quality Ratings System (QRS) and Quality Health Plan (QHP) Technical Specifications and call letter.
  - The Annual Call letter communicates updates/changes during the Measurement Year, as well as discusses future planning for the LOB.
- For the Exchange line of business, QRS are produced in a star-based rating. The overall rating includes member experience, medical care and health plan administration.

FEDERAL EMPLOYEE PROGRAM

- Clinical quality, customer service and resource use (QCR).
- FEP program works based on priority measures that are weighted.
- This system is administered by the Federal Employee Plan Directors
- FEP is known to members as the Service Benefit Plan.
- Current State Population for FEP: Around 89,000.
- In January 2025, FEP will launch the Postal Service Health Benefit (PSHB) program. This program designation is for members within USPS. For 2025, we do not anticipate any impacts to our current quality structure.

HEALTHY BLUE℠

- Rating System
  - Reporting of all health plan rating measures is required.
  - Adult and child health care quality measures.
  - Core set of children's health care quality measures.
  - Audit will be completed by an outside vendor, then submitted to NCQA.
  - Additional information can be found on www.HealthyBlueSC.com.

QUALITY NAVIGATOR PROGRAM

QUALITY NAVIGATOR PROGRAM

What is the Quality Navigator Program?

- Participation is based on primary care specialties
- Providers are automatically enrolled
- There is no cost to providers
- Multiple tools and offerings available to support providers

What is a Quality Navigator?

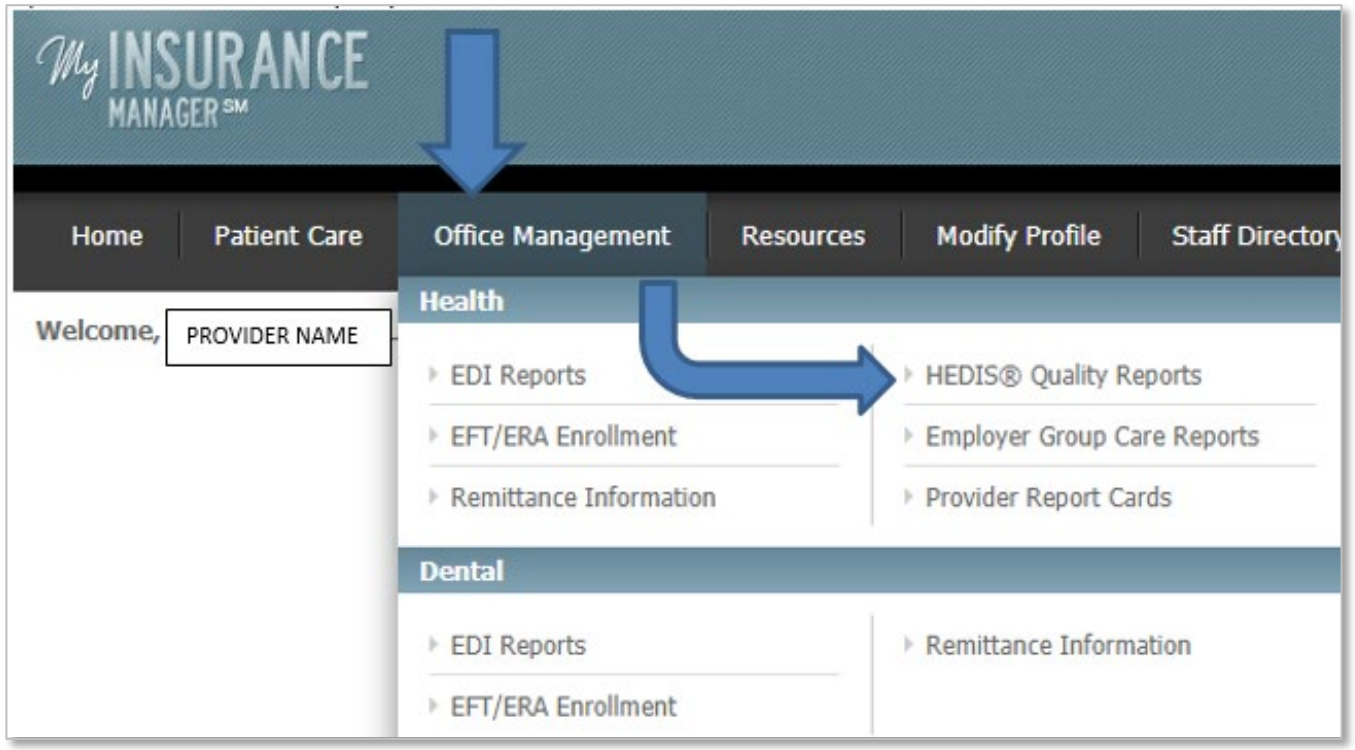
- Dedicated team member with a registered nursing license or related healthcare bachelor's degree
- Point of contact for care coordination and patient engagement
- Education representative that can schedule sessions to assist with understanding NCQA® measures, review open quality care opportunities and collaborate with providers to improve quality scores

QUALITY NAVIGATOR MODEL

- The quality navigator model is a population health and quality improvement program designed to assist primary care physicians (PCPs) in meeting quality metrics.
- The goal of the program is to assist PCPs by:
  - Streamlining care coordination.
  - Providing helpful tools and resources to support patient care efforts.
- Benefits of the Quality Program is that it:
  - Promotes accurate coding guidance.
  - Facilitates referrals to disease and case management programs to support treatment plans.
  - Assists with care coordination.
- Quality Navigator email: Navigator@bcbssc.com.

ACCESSING CARE REPORTS

Use My Insurance Manager℠ to access Care Opportunity Reports or Gap in Care (GIC) Report for Prospective Season.



UNDERSTANDING REPORTS

- Past medical history has been added for members (☐)
- Non-compliance can be a true “gap” in care or a “gap” in data (☐)
  - A true gap in care or non-compliance is when the member has not received the care.
  - A data gap is when the member has received the care, but this information was not shared with the plan.
  - Either way, the member will remain listed as “non-compliant” until the care is given AND that information is shared with us.
- Gap in Care report are available to access for providers **monthly** on My insurance manager portal.

First Name	Last Name	Date of Birth	Gender	Member ID_Card	LOB	Servicing Provider	Compliant Measures	Non-Compliant Measures	Past Medical History
John	Doe	1/1/1953	M	R12345566	Cross Exchange	My Provider	Acute Hospital Utilization, Acute Emergency Department Utilization	Colorectal Cancer Screening	Asthma COPD
Jane	Doe	1/1/1970	F	R12345566	Cross Exchange	My Provider	Controlling High Blood Pressure Breast Cancer Screening	Cervical Cancer Screening	Hypertension

RISK ADJUSTMENT DATA VALIDATION

RISK ADJUSTMENT

- Risk Adjustment (RA) is a Payment methodology used by Medicare Advantage health plan and ACA (Affordable Care Act) plans to adjust health plan payments based on the enrollee health status and demographic characteristics.
- Risk adjustment methodology relies on enrollee diagnosis as specified by the ICD-10CM guidelines to prospectively adjust payments for a given enrollee based on the health status of the enrollee.
- This process allows for the estimated cost to treat a patient in a given year and make sure health providers are paid fairly for the patients they treat.
- Records are requested the 3rd quarter of the year. We request records and review charts for chronic conditions that were not submitted via claims but affect patient care and can be captured for patient status.

RADV

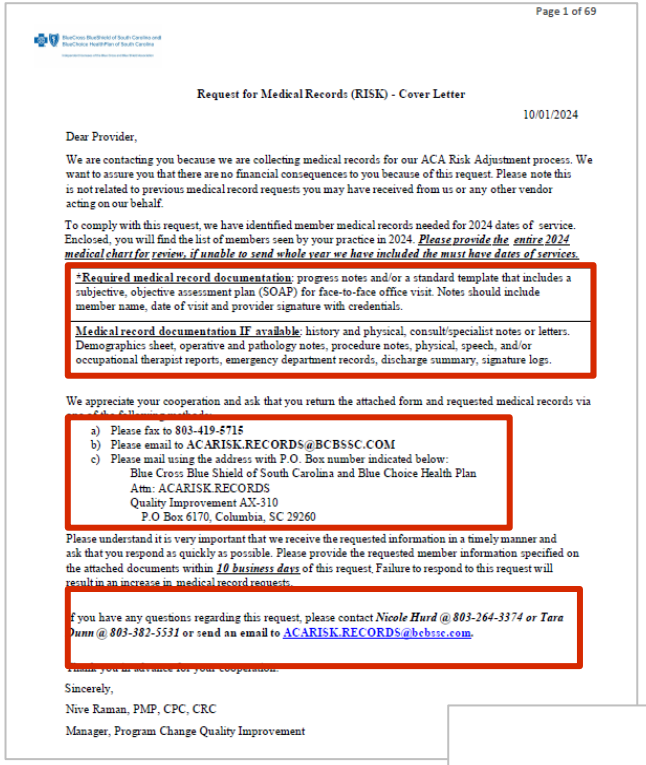
- Center for Medicare & Medicaid Services (CMS) has a formal audit program to monitor health plan compliance with HCC (Hierarchical Condition Category) reporting regulations. HCCs are sets of medical codes (ICD-10CM) that are grouped into related categories.
- The goal of RADV audits is to ensure that the health status submitted by the plan is supported by health record documentation and meets reporting guidelines.
- RADV is CMS primary way to address improper overpayments. Accuracy is confirmed from reviewing charts from providers and sending them to CMS for secondary review after an initial review by our selected auditor.
- CMS requires all HCC diagnoses be submitted each year the condition is present. It is of critical importance that plans ensure that members with HCC diagnoses be seen by a qualified provider and all current HCC diagnoses be evaluated and reported each year.
- Audit reviews the prior benefit year for our selected Cross and Choice members.
- HHS - RADV is conducted every year for all issuers and the project runs form June- December.

HOW RISK ADJUSTMENT HELPS PROVIDERS

- Allows sicker members to receive fairly priced coverage since healthy members offset the difference.
- Identifies potentially new problems early.
- Reinforces self-care and prevention strategies.
- Coordinates care collaboratively.
- Avoids potential drug-drug/disease interactions.
- Improves the overall patient health care evaluations process.
- Improved office practice patterns and communication among the patient’s health care team.

RISK COVER LETTER FOR RELEASE OF INFORMATION

- Letter includes:
  - Members information and dates of services we must have if they cannot provide the whole year.
  - The types of records we are looking for (i.e., office notes, consults, etc.).
  - How to return the records (i.e., fax, mail or email.).
  - How you can reach use if you have any questions.



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Request for Medical Records (RISK) - Cover Letter

10/01/2024

Dear Provider,

We are contacting you because we are collecting medical records for our ACA Risk Adjustment process. We want to assure you that there are no financial consequences to you because of this request. Please note this is not related to previous medical record requests you may have received from us or any other vendor acting on our behalf.

To comply with this request, we have identified member medical records needed for 2024 dates of service. Enclosed, you will find the list of members seen by your practice in 2024. ***Please provide the entire 2024 medical chart for review, if unable to send whole year we have included the must have dates of services.***

***Required medical record documentation**: progress notes and/or a standard template that includes a subjective, objective assessment plan (SOAP) for face-to-face office visit. Notes should include member name, date of visit and provider signature with credentials.

Medical record documentation IF available: history and physical, consult/specialist notes or letters. Demographics sheet, operative and pathology notes, procedure notes, physical, speech, and/or occupational therapist reports, emergency department records, discharge summary, signature logs.

We appreciate your cooperation and ask that you return the attached form and requested medical records via

a) Please fax to 803-419-5715
b) Please email to ACARISK.RECORDS@BCBSSC.COM
c) Please mail using the address with P.O. Box number indicated below:
Blue Cross Blue Shield of South Carolina and Blue Choice Health Plan
Attn: ACARISK.RECORDS
Quality Improvement AX-310
P.O Box 6170, Columbia, SC 29260

Please understand it is very important that we receive the requested information in a timely manner and ask that you respond as quickly as possible. Please provide the requested member information specified on the attached documents within ***10 business days*** of this request. Failure to respond to this request will result in an increase in medical record requests.

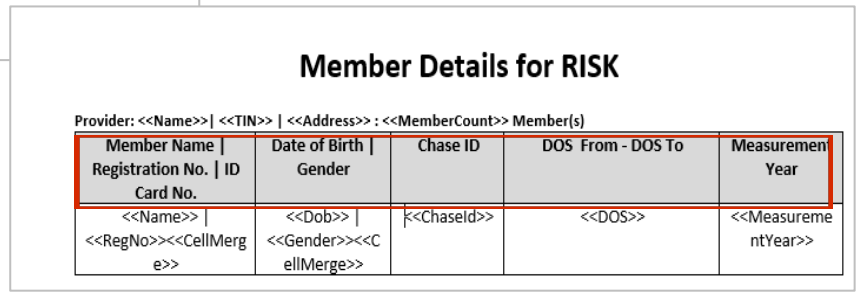
If you have any questions regarding this request, please contact ***Nicole Hurd @ 803-264-3374 or Tara Dunn @ 803-382-5531*** or send an email to ACARISK.RECORDS@bcbssc.com.

Thank you in advance for your cooperation.

Sincerely,

Nive Raman, PMP, CPC, CRC

Manager, Program Change Quality Improvement

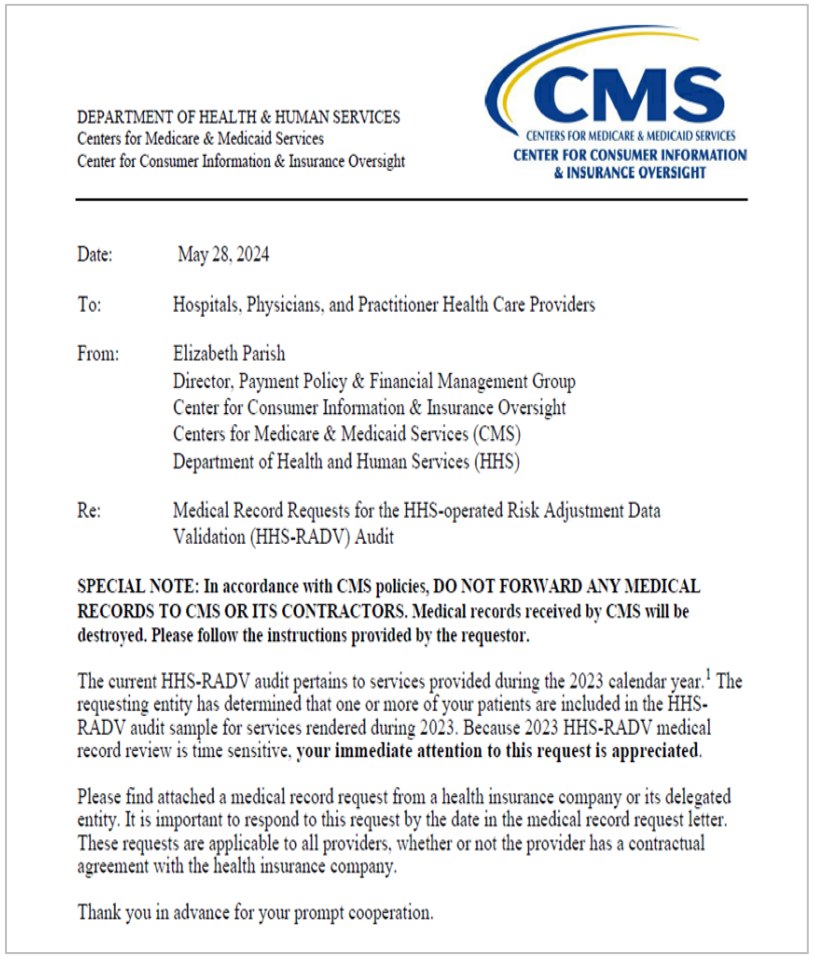


Member Details for RISK

Provider: <<Name>>| <<TIN>> | <<Address>> : <<MemberCount>> Member(s)

Member Name | Registration No. | ID Card No.	Date of Birth | Gender	Chase ID	DOS From - DOS To	Measurement Year
<<Name>> | <<RegNo>><<CellMerge>>	<<Dob>> | <<Gender>><<CellMerge>>	<<ChaseId>>	<<DOS>>	<<MeasurementYear>>

RADV COVER LETTER FOR RELEASE OF INFORMATION



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

Date: May 28, 2024

To: Hospitals, Physicians, and Practitioner Health Care Providers

From: Elizabeth Parish
Director, Payment Policy & Financial Management Group
Center for Consumer Information & Insurance Oversight
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services (HHS)

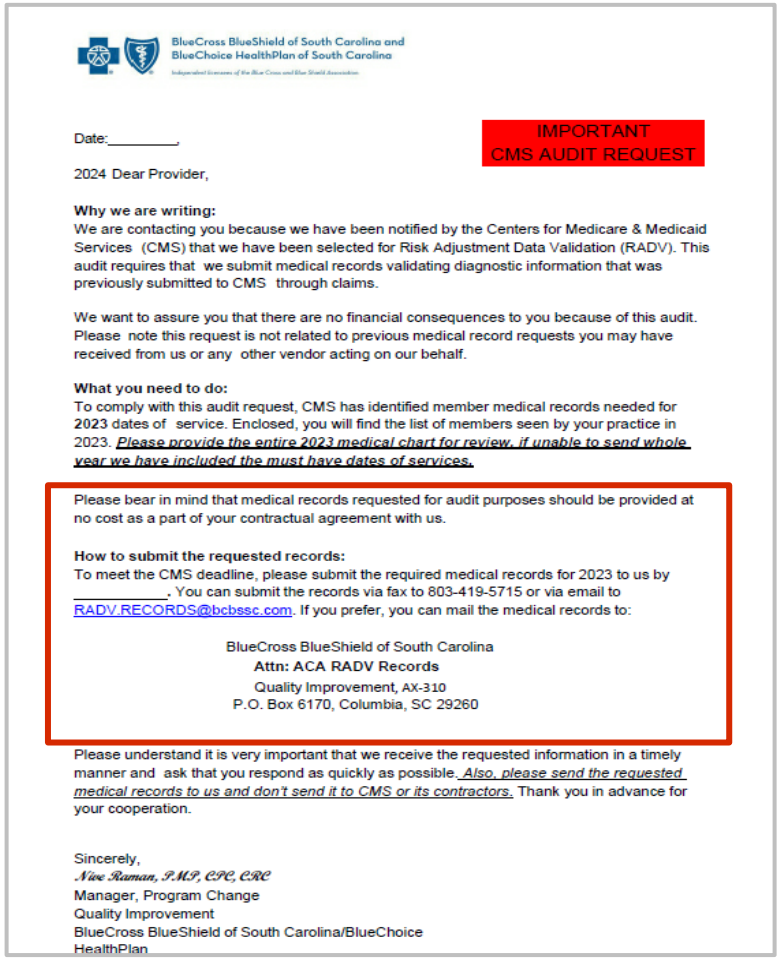
Re: Medical Record Requests for the HHS-operated Risk Adjustment Data Validation (HHS-RADV) Audit

SPECIAL NOTE: In accordance with CMS policies, DO NOT FORWARD ANY MEDICAL RECORDS TO CMS OR ITS CONTRACTORS. Medical records received by CMS will be destroyed. Please follow the instructions provided by the requestor.

The current HHS-RADV audit pertains to services provided during the 2023 calendar year.[1] The requesting entity has determined that one or more of your patients are included in the HHS-RADV audit sample for services rendered during 2023. Because 2023 HHS-RADV medical record review is time sensitive, **your immediate attention to this request is appreciated**.

Please find attached a medical record request from a health insurance company or its delegated entity. It is important to respond to this request by the date in the medical record request letter. These requests are applicable to all providers, whether or not the provider has a contractual agreement with the health insurance company.

Thank you in advance for your prompt cooperation.



BlueCross BlueShield of South Carolina and
BlueChoice HealthPlan of South Carolina

Date:_____,

IMPORTANT
CMS AUDIT REQUEST

2024 Dear Provider,

Why we are writing:
We are contacting you because we have been notified by the Centers for Medicare & Medicaid Services (CMS) that we have been selected for Risk Adjustment Data Validation (RADV). This audit requires that we submit medical records validating diagnostic information that was previously submitted to CMS through claims.

We want to assure you that there are no financial consequences to you because of this audit. Please note this request is not related to previous medical record requests you may have received from us or any other vendor acting on our behalf.

What you need to do:
To comply with this audit request, CMS has identified member medical records needed for **2023** dates of service. Enclosed, you will find the list of members seen by your practice in 2023. ***Please provide the entire 2023 medical chart for review, if unable to send whole year we have included the must have dates of services.***

Please bear in mind that medical records requested for audit purposes should be provided at no cost as a part of your contractual agreement with us.

How to submit the requested records:
To meet the CMS deadline, please submit the required medical records for 2023 to us by _____. You can submit the records via fax to 803-419-5715 or via email to RADV.RECORDS@bcbssc.com. If you prefer, you can mail the medical records to:

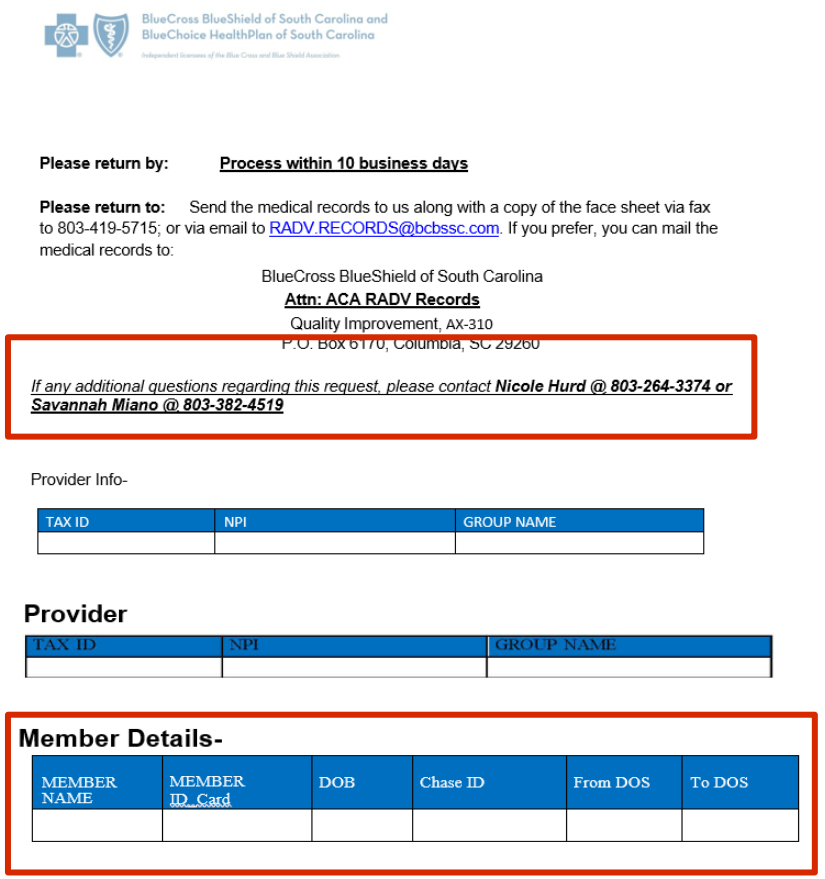
BlueCross BlueShield of South Carolina
Attn: ACA RADV Records
Quality Improvement, AX-310
P.O. Box 6170, Columbia, SC 29260

Please understand it is very important that we receive the requested information in a timely manner and ask that you respond as quickly as possible. *Also, please send the requested medical records to us and don't send it to CMS or its contractors.* Thank you in advance for your cooperation.

Sincerely,
Nive Raman, PMP, CPC, CRC
Manager, Program Change
Quality Improvement
BlueCross BlueShield of South Carolina/BlueChoice HealthPlan

RADV COVER LETTER FOR RELEASE OF INFORMATION (CONTINUED)

- Letter includes:
  - Members information and dates of services we must have if they cannot provide the whole year.
  - The types of records we are looking for (i.e., office notes, consults, etc.).
  - How to return the records (i.e., fax, mail or email.).
  - How you can reach use if you have any questions.



BlueCross BlueShield of South Carolina and BlueChoice HealthPlan of South Carolina

Please return by: **Process within 10 business days**

Please return to: Send the medical records to us along with a copy of the face sheet via fax to 803-419-5715; or via email to RADV.RECORDS@bcbssc.com. If you prefer, you can mail the medical records to:

BlueCross BlueShield of South Carolina
Attn: ACA RADV Records
Quality Improvement, AX-310
P.O. Box 6170, Columbia, SC 29260

*If any additional questions regarding this request, please contact **Nicole Hurd @ 803-264-3374 or Savannah Miano @ 803-382-4519***

Provider Info-

TAX ID	NPI	GROUP NAME

Provider

TAX ID	NPI	GROUP NAME

Member Details-

MEMBER NAME	MEMBER ID Card	DOB	Chase ID	From DOS	To DOS

RADV INVOICE RESPONSE LETTER

BlueCross BlueShield of South Carolina and BlueChoice HealthPlan of South Carolina
Independent licensees of the Blue Cross and Blue Shield Association

Date: 09/09/2024

FAX Coversheet

To: Medical Records Dept.
Fax No: XXX-XXX-XXXX
Pages: 1
From: Provider Education
Contact No: 803-264-4730

Re:

Your medical records vendor is billing BCBSSC for medical records that were previously received or requested.

The submission of medical records is a non-billable event. Network providers should submit medical records requested at no cost to BCBSSC when requested.

Please inform your medical records vendor and share this information with the appropriate staff.

BlueCross BlueShield of South Carolina and BlueChoice HealthPlan of South Carolina
Independent licensees of the Blue Cross and Blue Shield Association

09/9/2024

Re: Record invoice response

Hello,

As a company BCBSSC does not make payments for any medical records. Providers have a contractual obligation to send us the charts free of charge-please refer to your contract with us or call providers office if this is a third party vendor. It is addressed under IV.A(10) last sentence, "BCBSSC or the Associate Plan will have the right to inspect, review and obtain copies of such records upon request at no charge." All providers signed an individual HIX Agreement with this language in it. If you have any questions about the contract you may contact provider education 800-288-2227

Kindly let us know if you need any other details regarding the requests.

Thanks for your prompt attention to this time sensitive request.

Thank you,

Nive Raman, PMP,CPC,CRC
Risk Manager- Quality Improvement
BlueCross BlueShield of South Carolina
Phone: 803-264-4224
Nivedhitha.Raman@bcbssc.com
http://www.bcbssc.com/confidentiality.htm

Healthcare Innovation and Improvement | South Carolina

P.O Box 6170 Columbia, SC 29260-6170

www.southcarolinablues.com, www. BlueChoiceSC.com
An Independent licensee of BlueCross and BlueShield Association.

IV. PREFERRED PROVIDER'S RESPONSIBILITIES.

A. Preferred Provider shall:

(1) Accept payment of the Fee Allowance amount as payment in full for Covered Services rendered to Members. All payments are subject to the terms of the Member's Benefits Contract. Member shall be solely responsible for any required Patient Pay Amounts and Preferred Provider shall not bill the Member any amount in excess of such Patient Pay Amounts for Covered Services. Payment will be adjusted for payments made to Preferred Provider pursuant to any coordination of benefits provisions in any health plan other than the Benefits Contract.

(2) While performing services, maintain a physician-patient relationship with enrolled Members. Any and all medical service decisions, treatment decisions or exercises of medical judgment are Preferred Provider's responsibility.

(3) Not discriminate against any Member on the basis of race, color, sex, age, religion, national origin, handicap or insurance plan in providing services under this Agreement. Preferred Provider may choose to be closed to new Members as a group but only if Preferred Provider is closed to new patients from all payor sources.

(4) Cooperate and comply with the Provider Office Administrative Manual (located at www.southcarolinablues.com at the time of this writing).

(5) Use only HIX Network Providers in the delivery of Covered Services unless Covered Services, supplies or equipment are not available from any HIX Network Provider, or in the case of an Emergency.

(6) Provide Covered Services in an appropriate outpatient setting whenever safe, quality care can be provided in such a setting.

(7) Cooperate fully with the Utilization Management Program.

(8) Agree to provide a second opinion to Members who have already consulted with another HIX Network Provider.

(9) Cooperate and participate with BCBSSC and any Associate Plan in any utilization control procedures, quality assurance activities, analysis of Member's risk status, external audit systems and grievance procedures, as may be established pursuant to the terms of the Benefits Contract, and comply with all final determinations rendered through the grievance process.

(10) Maintain, with respect to each Member for whom Covered Services are provided under this Agreement, standard medical records in such form, containing such information, and meeting such record keeping requirements as might be required by applicable federal and state law. Preferred Provider will keep confidential, and take all reasonable precautions to prevent the unauthorized disclosure of any and all records prepared and/or maintained by this Agreement. BCBSSC or the Associate Plan will have the right to inspect, review and obtain copies of such records upon request at no charge.

HOW PROVIDERS CAN HELP THE PROGRAM

- The best thing you can do for your patients to keep this program going is have clear and thorough documentation in your notes.
- Another help is sending medical records as soon as request are received from insurer. Please call if you need help with pulling records. Help receive records from a third-party vendor in a timely manner.
- Only use the term “history of” if the patient no longer has this condition. Try using patient current medical conditions are… instead of patient with a history of.
- Address any chronic issue that may affect your decision making- coders are not doctors and can not make the connection if not clearly stated.
- Document all cause and effect relationships-document conditions which coexist at the time of the visit that require or affect patient care or treatment.
- More details on the condition are better for coding accuracy.

KEY TAKEAWAYS

POSITIVE IMPACTS ON QUALITY SCORES

Customer service

With every member's interaction

.

Schedule patients

Include periodic screenings and preventive services

Follow up on missed appointments

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Data Transfer

To reduce medical record requests or grant remote access to the quality navigator team.

Codes

Submit NCQA-approved quality codes on claims when appropriate.

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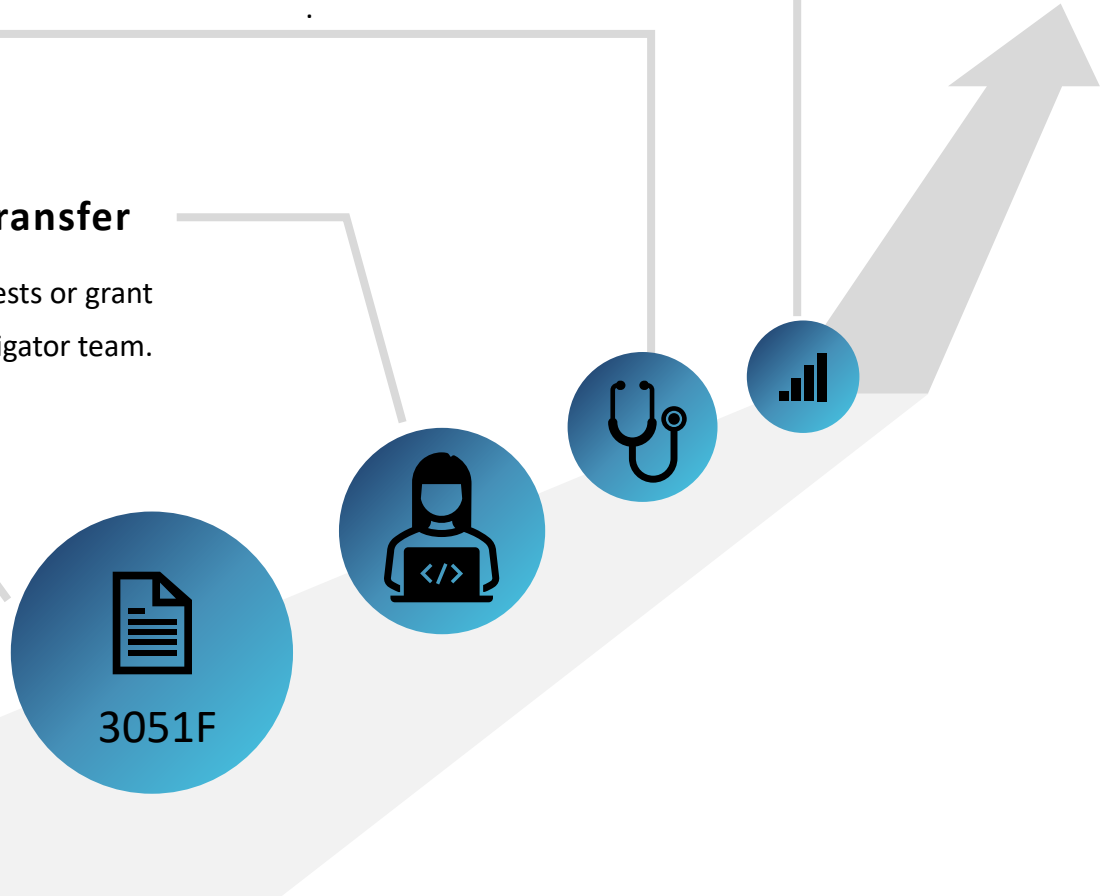

CONTACT INFORMATION

For questions or additional assistance, send an email to NAVIGATOR@bcbssc.com.

THANK YOU