WINTER 2021

ACQA ADVISOR

ACQA Advisor is a quarterly newsletter dedicated to sharing news, updates and best practices with our ACQA partners.

Excellus

CMO CORNER

Gregory G. Carnevale, M.D. M.B.A., vice president,
chief medical officer, Value-based Payments

2020 was one year to remember on many levels. Looking ahead, there are some important changes to our organization that pertain to value-based payment (VBP).

Organizational Changes

After three and a half years as chief medical officer, VBP, I have been offered the opportunity to become the vice president of Medicare affairs for retail markets at Excellus BlueCross BlueShield.

Brian Steele, D.O. has been named vice president medical affairs – clinical service and will have clinical oversight of VBP. Nicholas Massa, M.D., will assume the role of senior medical director and will also have clinical oversight of VBP.

It is likely that you have already worked with Drs. Steele and Massa in their previous roles at Excellus BCBS; however, I have provided additional information that may be of interest.

Brian K. Steele, D.O.

Vice President Medical Affairs – Clinical Services

Dr. Steele is board certified by the American Osteopathic Board of Family Physicians. He remains on clinical faculty at the University of Rochester and is also a member of the Monroe County Medical Society. He has served as Excellus BCBS chief medical officer – safety net/population management from 2018 to 2020, and as chief medical director for Envolve Health from 2017 through 2018.

Dr. Steele also served as associate chief medical information officer for the University of Rochester from 2010 to 2017. He has extensive experience in population health, analytics, quality and process improvement.

He is a graduate of Philadelphia College of Osteopathic Medicine where he also completed his internship and family medicine residency. After three years of practice in Philadelphia, Dr. Steele joined Highland Hospital and the University of Rochester. He is a past partner with Olsan Medical Group and held many leadership roles with the University of Rochester Center for Primary Care.

He resides in Pittsford with his wife Amy. They are proud parents of four children.

Nicholas Massa, M.D.

Senior Medical Director for Clinical Services

Dr. Massa is chair of the Health Plan's Corporate Medical Policy Committee. Previous primary areas of responsibility included leadership of corporate medical policy and over sight of medical coding/clinical editing. Dr. Massa also serves as a member of the Blue Cross Blue Shield Association's Medical Policy Panel, its Executive Committee and CPT Advisory Panel. In his new role, he will also provide leadership and expertise to specific areas of focus, including VBP partnerships, program development and affordability, and health care improvement/quality.

Dr. Massa is a graduate of SUNY Upstate Medical University where he completed a pediatric residency. Board certified in Pediatrics, he practiced general pediatrics for nearly 15 years prior to joining Excellus BCBS. Dr. Massa maintains a limited clinical practice and is a clinical assistant professor of pediatrics at Upstate Medical University.

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Looking Ahead to My New Role

One of the areas where I will be focusing on in my new role is the segment of the Medicare Advantage population that has underlying social determinants of health (SDOH) influencing their resource utilization and their underlying health conditions. There are organizations and programs in every community for your patients to access. During the COVID pandemic these services are available and useful support.

- Alzheimer's Association: https://www.alz.org/
- NY Connects : https://www.nyconnects.ny.gov/services/caregiver-resource-center-sofa5938
- Office on Aging: https://aging.ny.gov

Excellus BCBS is exploring two related pilots, one being with Lifespan and will cover Monroe, Ontario, Livingston counties. Lifespan provides connections to community resources for those who could benefit from extra support without additional out-of-pocket cost.

A suitable member may be experiencing one or more of the following:

- Unable to effectively self-manage
- Aging/stressed caregiver
- Lives alone
- Low health literacy
- History of non-adherence to treatment plan
- Co-morbidities, especially those that limit activities of daily living (ADLs)
- A need for assistance with benefits, housing and/or socialization
- Housing and financial instability
- Without caregiver support
- With substance abuse and mental health issues

Excellus BCBS is working on a second pilot with another community-based partner. Our hope is that connection with existing programs will allow for connection of participants to resources that support the clinical care goals and social determinants of health. We will share additional details when they are available.

Both pilots are centered on an organizational strategic focus or whole-person care. I look forward to communicating with all of you regarding the progress made in this regard. Please let me know if you have any questions about these pilots.

We know that you are focused on whole-person care as is Excellus BCBS. We understand that partnerships are needed now and will continue to be needed post pandemic.

We hope you will join us in making referrals to the many community-based organizations ready to provide service.

ECHO MOLST + eMOLST – A 'Telementoring' Approach to End-Of-Life Care Education

There are many ways that our value-based programs address variations of care and attempt to share best practices. Extension for Community Healthcare Outcomes (ECHO) programs are an example of the innovative ways Excellus BlueCross BlueShield works with many partner organizations and providers to ensure the health and well-being of our members during these challenging and unprecedented times.

ECHO is an all-teach-all-learn telementoring model that uses case-based learning. Specialists and experts at a "hub" meet regularly with clinicians at "spokes" via video conferencing to support specialty care service delivery. The ECHO model and virtual telementoring approach are well-suited to a time when we need to be physically separated, but the need for sharing knowledge and experience is greater than ever. This is particularly true regarding end-of-life care. To learn more about the ECHO model and its history, visit **echo.unm.edu**.

The goals of ECHO MOLST + eMOLST are to provide sustainable MOLST education and to improve the quality of thoughtful end-of-life discussions and documentation to ensure patient preferences are honored. Clinic series goals were updated to reflect the critical need for accurate documentation of these preferences amidst the rapidly changing situation with COVID-19. Participants quickly realized the value of this information, as indicated by the average number of attendees per clinic session, which rose from 26 to 53 from the spring to fall 2020 series.

Data Collected Using A Pre-Test, Post-Test Method From Each Clinic Series Proves That Echo Molst + Emolst Works.

In the fall 2020 series, participants' overall MOLST knowledge increased by

13%

Before the clinic series, only

36%

of respondents could identify that MOLST is not an advance directive.

After the clinic series, the number increased to

81%

To date, ECHO MOLST + eMOLST has provided end-of-life education to **826** participants from **116** **health care** organizations across the state.

Ability to identify, decision makers under New York State Public Health Law in a complicated end-of-life scenario rose by

21%

Participants also recognize the importance of their own advance care planning, with health care proxy completion rates among participants increasing by an average of

36%

More than

93%

of participants are directly involved in patient care, suggesting that quality improvements to patient care through education are immediate.

This rapid spread of knowledge is crucial to ensuring patient preferences for end-of-life are honored amidst a pandemic such as COVID-19.

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The next nine-week ECHO MOLST + eMOLST clinic series begins on March 4, 2021. Weekly lunch-hour video conferencing clinics begin with brief introductions and a 15-minute didactic presentation. This is followed by a 35 to 40-minute real patient case presentation given by a "spoke" using a Question & Answer and discussion format.

For more information on ECHO MOLST + eMOLST, including objectives and who should attend, visit molst.org/training/echo.

Don't miss out on this important educational opportunity. Contact Meg.Greco@Excellus.com to enroll in the next ECHO MOLST + eMOLST clinic series today.

CPT II Codes Help Bridge Gaps in Care

CPT II codes are five-character alphanumeric codes that supplement standard CPT codes (CPT I codes). These codes describe clinical components usually included in evaluation and management or clinical services and are not associated with any relative dollar value. CPT II codes can provide important information used in performance measurement and care management. When these codes are used, gaps in care are identified and can be closed more quickly to drive quality improvements. CPT II codes have the potential to save administrative dollars and time by eliminating the needs for tedious chart review and distribution. As a result, your staff can focus on other matters. CPT II code use has grown in popularity among health plans because it has proven to deliver positive results.

Tips for Billing CPT II Codes

CPT II codes are billed in the procedure code field and are billed with a $0 billable charge amount. While CPT II codes can be submitted on the globally billed claim, we encourage you to submit them at the time of service*.

Where Can I Find More Information About Quality Performance Measures?

Visit: **Provider.ExcellusBCBS.com.** You will need to login with your username and password.

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Which CPT II codes are used in billing for HEDIS® Quality Performance Measures?

Service Category	CPT II Code	Description
Prenatal/ Postpartum	0500F or 0501F	Initial prenatal care visit, must include date of LMP
	0503F	Postpartum care visit
Blood Pressure	3074F	Most recent systolic blood pressure less than 130 mm Hg
	3075F	Most recent systolic blood pressure 130-139 mm Hg
	3077F	Most recent systolic blood pressure greater than or equal to 140 mm Hg
	3078F	Most recent diastolic blood pressure less than 80 mm Hg
	3079F	Most recent diastolic blood pressure 80-89 mm Hg
	3080F	Most recent diastolic blood pressure greater than or equal to 90 mm Hg
Diabetes - HgbA1c	3044F	Most recent hemoglobin A1c (HbA1c) level less than 7.0%
	3046F	Most recent hemoglobin A1c level greater than 9.0%
	3051F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0%
	3052F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0%
Diabetes - Eye Exam	2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy
	2023F	Dilated retinal eye exam with nterpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
	2024F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy
	2025F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
	2026F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy
Diabetes - Eye Exam Continued	2033F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy
	3072F	Low risk for retinopathy (no evidence of retinopathy in the prior year)
Diabetes - Nephropathy (Medicare Members Only)	3060F	Positive microalbuminuria test result documented and reviewed
	3061F	Negative microalbuminuria test result documented and reviewed
	3062F	Positive macroalbuminuria test result documented and reviewed
	3066F	Documentation of treatment for nephropathy (e.g., patient receiving dialysis, patient being treated for ESRD, CRF, ARF, or renal insufficiency, any visit to a nephrologist)
	4010F	Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) therapy prescribed or currently being taken
Medication Reconciliation Intervention	1111F	Discharge medications reconciled with the current medication list in outpatient medical record

*Our Prenatal and Postpartum Care (PPC) CPT II Code Program allows prenatal and postpartum codes 0500F or 0501F and 0503F, only, to be eligible to earn a $15 financial incentive if billed with a $15 charge.
Note: this program is subject to change.

Spine Health:

Program Addresses Consistent Provider, Patient Stressors

An interesting systemic review was published in the journal **Pain** recently that found fewer than 20% of patients presenting to their primary care practitioner (PCP) with low-back pain received evidence-based information and advice[1]. This, despite multiple, similar international clinical guidelines that recommend encouraging activity, discourage routine ordering of imaging and limit prescription of opioids.

When researching factors contributing to PCP burnout, another study found "poor patient adherence and self-management" was the strongest factor noted by both high-and-low-stress reporting PCPs[2]. The knowledge and comfort gap between spine providers and patients upon early contact needs to be bridged.

These are examples of the issues we wish to resolve in our communities through our Spine Health Program. The condition of lower-back pain has more than 10 formal clinical guidelines from around the world. Yet,we have witnessed exponential increases in the direct and indirect costs of back pain over the past two decades, with tremendous variation in back pain care. A clinical care pathway, as imbedded in the Spine Health Program, is a change in the structure and the processes of a guideline. A pathway can be thought of as the application of a guideline in the broader context of a health care delivery system. Key elements constituting a clinical care pathway include:

A specific care algorithm that defines best evidence and patient expectations

Enhanced communication (most notably by incorporation of evidence-based care)

Coordination of care (to include multiple disciplines)

A classification system

Allocation of resources to ensure sustainability

Continued monitoring of outcomes (including stakeholder satisfaction) and processes, with focus upon the point of entry of the patient into health care system[3]

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A clinical care pathway puts the patient at the center, builds an evidence-based guideline for care around the patient, and only then, adds those providers who bring value to the delivery of care. Value is defined as quality outcomes balanced by cost. While a pathway considers health care for a specific condition, a clinical care platform considers families of conditions with a platform of care built around commonalities of this family of conditions. Platform-based care is provided by those who provide the highest quality service, satisfy the requirements of the patient and are least expensive to employ[4]. Our goal is, with the help of community providers, to expand the success of the Spine Health Program pathway into a musculoskeletal platform over the next couple of years.

Help us Help You

The workload of the individual practitioner decreases, and the overall success of the program improves as more providers,systems, employers and patients are exposed and embrace an evidence-based, patient active, biopsychosocial model addressing spine related disorders. The Spine Health Program directly addresses these needs through it's free 2-CME PCP spine pathway workshop available on-line, 24/7. Go to https://primaryspineprovider.com/excellus-bcbs-pcp-registration/ f for information and registration.

Needs also are addressed through our current patient/provider toolbox of shared decision tools, educational materials and exercises/self-care suggestions. All Excellus BlueCross BlueShield participating PCPs received a mailer recently with invitations to the nationally recognized spine pathway workshops, access to the toolbox and materials for their treatment rooms.

We are also working with regional medical societies to coordinate our back-care guidelines. Any assistance you can give on any of these fronts through contacts with medical societies, discussions with radiologists to include the 'common findings' chart in MRI reports, or by encouraging PCP workshop attendance would be greatly appreciated!

Please send your ideas or questions to:
brian.justice@excellus.com

1. What is usual care for low back pain? Kamper, et al. A systematic review of health care provided to patients with low back pain in family practice and emergency departments, Pain, 2020
2. Z. Weiner, et al. Primary Care Physician Stress Driven by Social and Financial Needs of Complex Patients, J Gen Intern Med, 2019
3. Fourney et al. A systematic review of care pathways for lower back pain and introduction of the Saskatchewan spine pathway. Spine 2011
4. Bohmer et al. Care platforms: a basic building block for care delivery. Health Affairs 2008

Metabolic Syndrome Can Lead to Costly Complications

Excellus BlueCross BlueShield's nurse navigators identify members at risk for metabolic syndrome based on elevated glucose or prediabetes, hypertension, and hyperlipidemia to allow and review for appropriate management and treatment considerations.

Metabolic Syndrome Risk Factors

- Large waistline.
- High triglyceride level (or on medicine to treat high triglycerides). (E78.1, E78.2, E78.49, E78.5)
- Low HDL cholesterol level (or on medicine to treat low HDL cholesterol). (E78.6)
- High blood pressure (or on medicine to treat high blood pressure). (I10)
- High fasting blood sugar (or on medicine to treat high blood sugar). (R73)

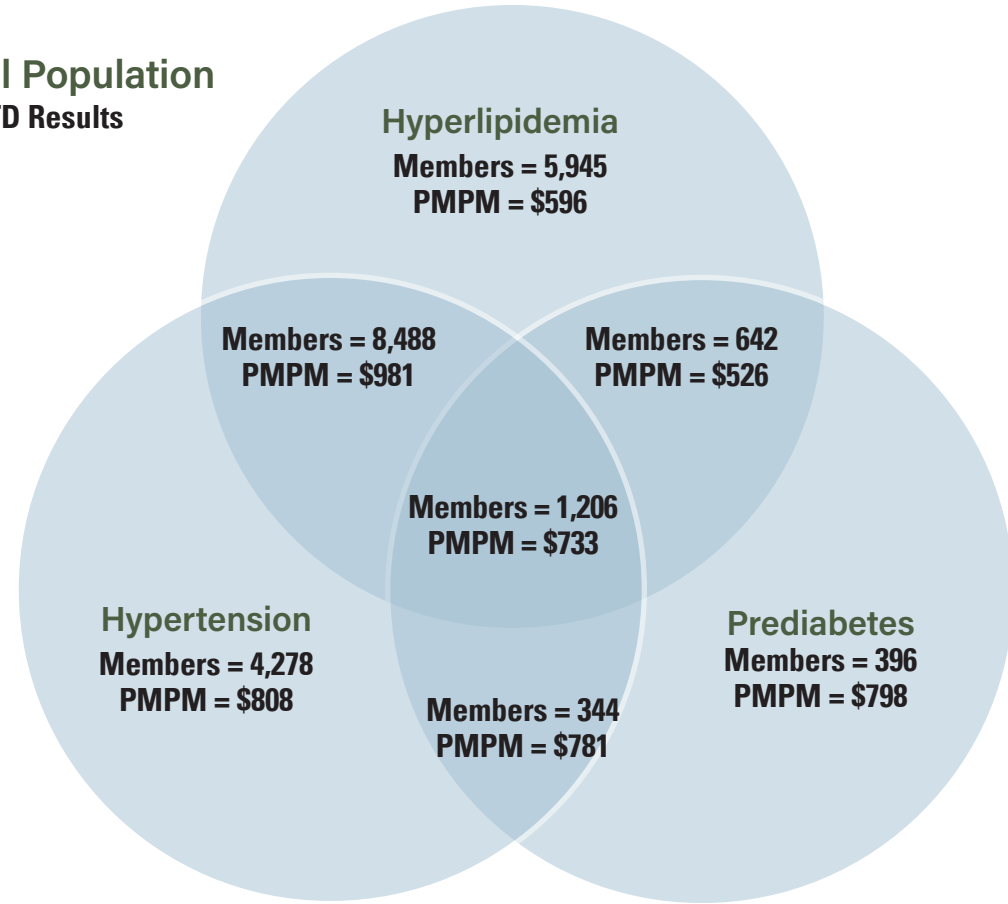
At least three metabolic risk factors need to be present to be diagnosed with metabolic syndrome (E88.81)

Metabolic syndrome is closely linked to an inactive lifestyle and excessive weight or obesity. It is also associated with insulin resistance and can lead to more severe and costly chronic conditions such as stroke, diabetes and heart disease.

Example data pulled from a nurse navigator report is shown in the accompanying chart.

Commercial Population

October 2020 YTD Results



Reducing the risk of ischemic heart disease is the major goal in managing patients who have metabolic syndrome. Heart-healthy lifestyle changes are generally the first line of treatment followed by medication as necessary. Evaluating and monitoring medication adherence for those patients prescribed medications can help reduce the risk of developing more severe illness or complications such as heart attack or stroke.

ICER is Redefining Drug Value

The Institute for Clinical and Economic Review (ICER) is an independent research organization started in 2006 by Dr. Steven Pearson within Massachusetts General Hospital. The goal is to evaluate the clinical and economic value of various health care delivery innovations objectively and transparently.

But what is "value"? Unfortunately, there is no easy answer. For example, manufacturers who just spent extensive amount of money on research and development of a new drug may base value on those costs; the patient may base value on how many days they can spend at home instead of the hospital; the insurer may base value on the drug's individuality and cost-effectiveness.* ICER takes all these viewpoints into account to help provide nonpartisan guidance that is accessible to the public.

ICER has a prominent role in new-drug valuation. Once a new drug is approved for market, ICER acts as an independent check by assessing the drug and establishing a value-based price, referred to as the health-benefit price benchmark. There are four questions included in this assessment to be answered by expert panels of stakeholders **Table 1**. It's important to understand that ICER does not have authority to forcibly change the manufacturer's price but provides more transparency into determining whether the cost is reflective of its potential benefit.

Table 1

DRUG ASSESSMENT REPORT QUESTIONS TO BE ANSWERED BY PANELISTS
How well does the drug work?
How much better is the new drug than what is already available?
How much money could it save?
How much would it cost to treat everyone who needs it?

For example, panelists are currently assessing the value of Biogen's aducanumab, a novel and potential disease-modifying treatment for Alzheimer's disease, which demonstrates debatable clinical effectiveness. ICER's review, and the transparency of it, may be able to help provide guidance on the true cost effectiveness of the drug. Please review **Table 2** for some examples of actual costs compared to ICER recommendations.

ICER's model is implemented already, on some level, in several health care delivery industries. Evidence-based decisions are made frequently on the value and necessity of drug therapy to uphold and/or adjust policies, but several challenges can emerge in the decision-making process.

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Table 2

Drug	Manufacturer's Price	ICER's Value	Lower/Higher/Within Range
Icosapent Ethyl (Vascepa)	$3,699	$6,282-$9,204	Lower
Dupilumab (Dupixent)	$31,000	$30,516-$43,726	Within Range
Rivaroxaban (Xarelto)	$5,457	$5,223-$7,597	Within Range
Elagolix (Orilissa)	$10,138	$8,800-$12,800	Higher
Elexacaftor/tezacaftor/ivacaftor and ivacaftor (Trikafta)	$311,741	$67,900-$79,900	Higher

Maintaining satisfaction within all parties involved—the manufacturer's desire to be profitable and innovative, the patient's and physician's desire for quality and affordable care, and the insurer's desire to balance cost and efficacy is an inherently difficult task. While a perfect balance of satisfaction may never be reached, we can work toward that goal by using ICER reports to consider all elements of value and drive meaningful decisions among payers, health systems, and manufacturers.

These efforts are essential in supporting ICER's mission in creating a more effective and efficient health care system.

For more information or to review reporting, please visit icer.org

*data indicative of its ability to achieve a reduction in health care-associated costs