Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

PROVIDERS' NEWS

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Episodes of Care to be Phased Out

Arkansas Blue Cross and Blue Shield will be phasing out its Episodes of Care program in conjunction with ongoing efforts to implement the Value-Based Compensation Initiative (VBCI).

The Arkansas Blue Cross Episodes of Care program (which bundles payments for services associated with 12 condition-specific health episodes) initially was implemented in January 2013 as part of the Arkansas Healthcare Payment Improvement Initiative (AHCPII). The multi-payer program began as an effort to address broad variation in the efficiency of care provided within specific episodes – variation driven by multiple factors, including practice patterns and care settings.

In the years since it was first implemented, the Arkansas Blue Cross Episodes of Care Program has been successful in creating transparency associated with variation in treatment and cost. This transparency has enabled improvements in care and compression of cost variation within these episodes, and these improvements have been important to the continued transition of the healthcare system toward a more consumer-centric system, focused on sustainability and the delivery of greater value for purchasers. To continue this evolution to greater sustainability and value, broader focus and scalability are needed than available through the current Episodes of Care Program. As we move into a broader scope of value-based payment, we intend to utilize and build upon the components of episodic incentives that were successful. This notice is to advise you that Arkansas Blue Cross will be phasing out its Episodes of Care Program. This will allow Arkansas Blue Cross to focus resources on its current efforts to implement the Value-Based Compensation Initiative, which is planned to have broader participation than the Episodes of Care Program.

This means that Arkansas Blue Cross will suspend the Episodes of Care program for the 12 currently active episodes effective December 31, 2018. Reporting for the 2018 episodes will be performed during the remainder of calendar year 2018 and throughout 2019 (see important dates in the following table). However, we will not establish 2019 episode financial targets or send contracts for 2019.

Important dates related to phasing out the Episodes of Care model

Report Quarter	Report Publishing Date	Report Span
Quarters 1 & 2 – 2018	December 31, 2018	January – June 2018
Quarter 3 2018	January 31, 2019	January – September 2018
Quarter 4 2018 – (Preliminary Year-End Report)	April 30, 2019	January – December 2018
Quarter 4 2018 – (Final Settlement Report)	July 31, 2019	January – December 2018

Other Arkansas Blue Cross value-based programs [Comprehensive Primary Care Initiative Plus (CPC+), Patient Centered Medical Home (PCMH) & Collaborative Health Initiatives] will remain operational.

Value-Based Compensation Initiative

This article provides an update regarding the Value-Based Compensation Initiative (VBCI).

In the September *Providers' News,* we communicated that stakeholder meetings were continuing and that modifications also were ongoing, based on feedback from stakeholder meetings. At the time of the September *Providers' News* article, we were working toward a release of "shadow reports" by the end of this calendar year.

Since September, Arkansas Blue Cross has held several more stakeholder meetings, including limited sharing of draft reports. Those meetings continue to generate feedback that is being used to make modifications to measures and report formats. We also are working with RowdMap to ensure more transparency of the measures, specifically numerator and denominator information.

Given the status of our current work and coordination with stakeholders, "shadow reports" will not be released before the end of this year, as we have been working toward. Rather, our stakeholder meetings will continue, we'll share draft information and receive feedback, and we'll make improvements to the program until we're satisfied that the program is ready for a broad release of "shadow reports."

The bottom line is that we are placing priority on accuracy over speed. The eventual broad release of "shadow reports" will "trigger" a 12-month shadow reporting period, as has been previously communicated. Therefore, providers will have a full year of access to information prior to the commencement of value pool contributions.

As had been our practice, we will give updates on the implementation of VBCI through *Providers' News*, which currently is published quarterly.

New Prepay Review of High-dollar Inpatient Claims

As part of a new policy required by the Blue Cross Blue Shield Association, beginning January 1, 2019 Arkansas Blue Cross and Blue Shield and its family of affiliates are implementing a new prepay review process for certain Arkansas inpatient claims that have a total billed amount of $250,000 or greater. This process will require providers to submit an itemized bill for review, along with inpatient claims of $250,000 or more that have a payment tied to the billed charge (i.e. not paid by per diem, case rate or diagnosis-related group). This review includes interim bills where the total of all bills is $250,000 or more.

Arkansas Blue Cross will use the services of Equian to conduct this prepay review. Arkansas Blue Cross will evaluate the results of the prepay review to determine whether the billed amount subject to review should be adjusted.

To minimize any delays or interruption of payments of these claims, providers are asked to submit an itemized bill with any claims that meet this criteria, beginning with January 1, 2019 admission dates.

As was mentioned, this is a requirement from the Blue Cross Blue Shield Association and should be considered a formal contractual change notification for the Arkansas Blue Cross and Blue Shield Preferred Payment Plan, USAble Corporation's Arkansas' FirstSource® PPO, and True Blue PPO, and Health Advantage HMO.

Claims Incurred During the Credentialing Process

Arkansas Act 1232 requires payers to complete their credentialing process for physicians within 60 days of receiving a completed application. The law allows for certain circumstances where the clock is stopped during the credentialing process. Arkansas Blue Cross and Blue Shield and its family of companies consistently meet or beat this turnaround time requirement for physicians and nonphysician providers.

In addition, once a physician's application has been approved through the payer's credentialing process, Act 1232 requires a physician's network participation effective date to be backdated to the day the payer received a completed application. Arkansas Blue Cross applies this rule to physicians and nonphysician providers.

We ask that providers hold their claims and not bill us until the provider receives the notice from Arkansas Blue Cross that his or her credentialing has been fully completed and approved. Billing prematurely only causes unnecessary problems for the providers and our members.

Act 1232 offers protection to physicians against unacceptable credentialing wait times. In addition, Arkansas Blue Cross has been able to provide compliance to these requirements. As a result, Arkansas Blue Cross, USAble Corporation and Health Advantage have enacted a policy effective immediately that we will **not** adjust claims from providers who file their claims during their credentialing process. In addition, our members cannot be billed and held responsible for more than their applicable in-network deductible, copay and/or coinsurance amounts. Again, we ask providers to hold your claims until you receive our letter indicating full network participation.

This article is considered an official notification of a policy change for Arkansas Blue Cross, USAble Corporation and Health Advantage.

Radiology Vendor Changes from National Imaging Associates to AIM Specialty Health

Effective January, 1, 2019, Arkansas Blue Cross and Blue Shield and its family of companies will transition the administration of advanced diagnostic imaging from National Imaging Associates (NIA) to AIM Specialty Health (AIM) for its fully insured members. The decision was the result of a proposal process, from which AIM clearly emerged as an excellent choice to serve our members and company. AIM already serves Arkansas Blue Cross through oncology.

Why the change?

AIM administers services nationwide, which will allow us to serve members outside the Arkansas service area through a single vendor. AIM serves about 50 health plans and related organizations, representing more than 42 million people. The AIM staff of 1,000 associates includes 600 healthcare professionals (licensed in all 50 states, with board certification in more than 20 specialties and subspecialties).

What changes for providers and members?

This transition will be seamless for the vast majority of our fully insured members. Here are some important notes on the transition:

Effective date – The move from NIA to AIM is effective January 1, 2019.

Phone number – Arkansas Blue Cross purchased the telephone number, 1-877-642-0722, listed on the back of some member ID cards, and will redirect it to AIM. Members or providers calling for diagnostic imaging pre-authorization will follow the same process as before the vendor change. Hours are Monday - Friday from 7 a.m. to 7 p.m. CST.

ID cards – No member will receive a new ID card solely because of the move to AIM.

Websites – All of our network websites will link providers to AIM's website. Get fast, convenient online service via the AIM ***Provider****Portal*$_{SM}$, (registration required). ***Provider****Portal* is available 24/7. Go to www.providerportal.com to begin and register prior to January 1, 2019.

The following information is needed to submit a request to AIM:

- Member's identification number, name, date of birth and health plan
- Ordering provider information
- Imaging provider information
- Imaging exam(s) being requested (body part, right, left or bilateral)
- Patient diagnosis (suspected or confirmed)
- Clinical symptoms/indications (intensity/duration).

Skilled Nursing Facility Provider Agreements

Arkansas Blue Cross and Blue Shield and its family of affiliates (including USAble Corporation and Health Advantage) mailed commercial network provider agreements to skilled nursing facilities in October. Historically Arkansas Blue Cross has not offered provider contracts to skilled nursing facilities, and our case managers have negotiated terms and reimbursement.

Effective January 1, 2019, all of that changes. In order for a skilled nursing facility to be considered in-network, it must meet our credentialing standards, and its contracting officer must sign provider agreements. This includes commercial networks such as the Arkansas Blue Cross Preferred Payment Plan, USAble's Arkansas' FirstSource® PPO, True Blue PPO networks and Health Advantage.

All skilled nursing facility admissions must have prior approval from our utilization management division, and the patient must be followed by our case management team. Until now, skilled nursing facilities have received the in-network claims and benefit adjudication through our case managers' approvals. This arrangement will end January 1, 2019. As of that date, all skilled nursing facilities will be required to meet credentialing standards and sign formal contracts.

Facilities that have not received skilled nursing facility commercial agreements but believe they should have should contact the nearest regional office's network development team.

Testing for Drugs of Abuse or Drugs at Risk of Abuse, Including Controlled Substances

Arkansas Blue Cross and Blue Shield has a coverage policy for testing for drugs of abuse or drugs at risk of abuse, including controlled substances (Policy #2009013). This coverage policy requires a precedent screening (presumptive) test for each specific drug or drug class prior to confirmatory (definitive) drug testing.

> ***Note: Urine drug testing is expected to be performed by in-network providers. Referral to out-of-network providers – including labs – constitutes a breach of the network participation agreement except where referral is unavoidable due to an emergency or if a covered service is not available in-network. For a list of current in network laboratory service providers, visit the Arkansas Blue Cross website at www.arkansasbluecross.com.***

Effective January 01, 2019, services performed for urine testing for drugs of abuse or drugs at risk of abuse should be submitted according to the following guidelines:

Screening (Presumptive) Testing

- Three CPT codes are available for drug screening (presumptive testing). These codes include 80305, 80306, 80307. Please note that per coverage policy #2009013, services billed using CPT 80307 do not meet member benefit certificate primary coverage criteria and are not covered.
- Only one presumptive code (80305 or 80306) may be billed per day.
- There is a maximum limit of one unit of procedure codes 80305 and 80306 per date of service.
- There is a limit of 24 screening services per year (combined total of 80305 and 80306).

Confirmatory (Definitive) Testing

- Confirmatory (definitive) testing should be billed using the HCPCS codes G0480-G0482 and G0659 as appropriate.
- Please note that per coverage policy #2009013, services billed using HCPCS G0483 do not meet member benefit certificate primary coverage criteria and are not covered.
- Only one of the five definitive codes (G0480, G0481, G0482, G0483, G0659) may be billed per day.

- There is a maximum limit of one unit of procedure code G0480-G0483 and/or G0659 per date of service.
- There is a limit of 24 confirmatory services per year (combined total of G0480-G0482 and/or G0659)

Confirmatory (definitive) drug testing performed on saliva, hair, sweat or nails is not covered.

For definitive testing, the selection of the correct definitive G code to bill is based on two factors:

1. The use or absence of specific (1) calibration controls, (2) quality controls, and (3) internal standards. (CMS, 2017)
2. The number of drug classes documented as tested.
    - The available drug classes are specified by CMS.
    - The AMA CPT Manual may be consulted for examples of individual drugs within each drug class.

Report a code from range G0480 – G0483 if the drug testing method utilized "stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength)" and "method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift)." (CMS, 2017)

G0659 must be reported if the definitive drug testing method was performed:

- Without method or drug-specific calibration,
- Without matrix-matched quality control material, or
- Without use of stable isotope or other universally recognized internal standard(s) for each drug, drug metabolite or drug class per specimen.

Specimen validity testing is not eligible to be separately billed under any procedure codes (e.g. 81000, 81001, 81002, 81003, 81005, 81099, 82570, 83986, or any other code). This is because for all codes in range 80305 – 80307 & G0480 – G0483, G0659, the code description indicates that this testing is included if it was performed.

CPT codes 80320-80377 are not accepted for processing claims. These services should be reported with G0480-G0483, G0659.

Please see the complete coverage policy for details on coverage criteria for testing of drugs of abuse. The complete coverage policy #2009013 can be accessed on the Arkansas Blue Cross website under the "Coverage Policy" page under the "Doctors and Hospitals" at www.arkansasbluecross.com/members/other_links/coverage_policy.aspx.

Think Twice Before Prescribing Antibiotics for Bronchitis

An uptick in acute bronchitis usually occurs in patients during winter

Bronchitis may or may not require an antibiotic as it can be both viral and bacterial. The most common pattern is for bronchitis to start as a viral infection, but bacterial bronchitis can follow a viral infection of the upper respiratory system, such as cold or flu. In fact, it is possible to have both viral and bacterial bronchitis at the same time.

Acute bronchitis can come on suddenly as the tubes that carry air to your lungs become inflamed. Acute bronchitis can cause wheezing, chest tightness and shortness of breath. It usually lasts about 3-10 days, but can last as long as three weeks. The cough, however, can linger much longer. Acute bronchitis usually gets better on its own without the need for antibiotics.

The Centers for Disease Control and Prevention (CDC) website states that at least 30 percent of antibiotic courses are prescribed unnecessarily for acute respiratory conditions such as colds, bronchitis and sore throats that are caused by viruses.

Additionally, the CDC states that antibiotic use is the most important modifiable driver of antibiotic resistance. Antibiotic-resistant infections lead to higher healthcare costs, poor health outcomes and more toxic treatment.

Any time antibiotics are used, they can cause side effects and lead to antibiotic resistance. Antibiotic resistance is one of the most urgent threats to the public's health.

Each year in the United States, at least 2 million people get infected with antibiotic-resistant bacteria. At least 23,000 people die as a result.

Antibiotic stewardship is much needed for clinics and facilities that routinely provide treatment. Antibiotic stewardship is the effort to measure and improve how antibiotics are prescribed and used. Improving antibiotic prescribing involves implementing effective strategies to align them with evidence-based recommendations for diagnosis and management.

Providers should implement at least one policy or practice to improve antibiotic prescribing, assess whether it is working and modify as needed. Providers should also give educational resources to patients on antibiotic prescribing. Patients always should know to take their antibiotics exactly as prescribed.

Regardless of diagnosis, providers always should ask: Does this have an infection that will respond to antibiotics? For example, providers should not prescribe an antibiotic for acute bronchitis because antibiotics are not recommended as treatment. Ultimately, it is best to determine if a case of bronchitis is viral or bacterial before prescribing an antibiotic. In addition, data on antibiotic prescribing is now being tracked and reported in various quality measures.

How to Avoid Prescription Drug Exception Requests While Helping Patients Save Money

Your electronic health record (EHR) may allow you to view real-time, patient-specific drug coverage at the point of prescribing, which could allow you to:

- Know whether the drug you want to prescribe is covered under your patient's prescription drug plan.
- Know what patients will pay out of pocket based on their specific benefits – this cost may be based on copay or coinsurance and/or the amount of the deductible that remains to be satisfied.
- See a list of clinically appropriate lower cost brand and generic alternatives that you could consider prescribing to save your patients money (**Response time within 1 second**).
- Understand which therapy options require prior approval (PA) or have other restrictions such as step therapy or quantity limits.
- Initiate most prior approvals directly from your EHR and receive a "near real-time" approval decision (**Decisions on electronic PAs can be delivered as quickly as 6 seconds**).
- Ensure the pharmacy you select is in your patient's network.

There's ***no charge*** for this functionality – you just need the latest version of your EHR. The following systems and versions are providing real-time prescription benefits:

EHR Systems and Versions Enabled
Aprima Medical Software (v2016 – 16.0.1612.2146)
Cerner Millennium (v2015.01.25)
Epic (Epic 2018)
Modernizing Medicine
Office Ally
Practice Fusion
Waiting Room Solutions (v5.0)
e-Prescribing Solutions Enabled
Allscripts ePrescribe
e-Prescribing Solutions Enabled

DrFirst
eazyScripts (v3.0)
InstantDx OnCallData (v5.0)
Other Provider Solutions Enabled
Asembia
Careform
Claimat
ReMY Health
United Biosource
VirMedica

If you don't see your EHR vendor or version listed, contact your EHR vendor and tell them your providers need patient-specific drug benefit and cost information in their e-prescribing workflow. Ask if they have contracted with Surescripts for real-time prescription benefits.

If you are not using the most recent version of your EHR's system, contact your EHR vendor account manager. For Epic users, contact your Epic account manager to confirm your 2018 upgrade "go-live" date. Work with your Surescripts account manager to complete the contract addendum.

Still having trouble accessing real-time prescription benefits? Contact your EHR vendor's help desk support line. For Epic users, work with your Ambulatory and Bridges TS representative and log a ticket with Surescripts.

Join more than 700 prescribers for Arkansas Blue Cross, Health Advantage, USAble Mutual and select groups with BlueAdvantage Administrators of Arkansas and USAble Administrators that have used this functionality through innovations from CVS Caremark. Physicians who have access to real-time prescription benefits information at the point of prescribing are selecting lower-cost alternatives 40 percent of the time and, when such a choice is available, saving an average of about $130 per fill.

Standard Formulary Removals and Updates

Therapy classes with drug removals and updates for 2019

New Formulary Exclusions

Class	Product	Preferred Alternatives
Antiemetic	ZUPLENZ	granisetron, ondansetron, SANCUSO
Anti-Infective	ACTICLATE	doxycycline hyclate
DPP4 and biguanide combinations	JENTADUETO XR, TRADJENTA	JANUVIA
Growth Hormone	NORDITROPIN	GENOTROPIN, HUMATROPE
Ophthalmic	AVENOVA	Consult physician
Sodium-Glucose Co-transporter 2 (SGLT2) Inhibitors and Combination Products	INVOKANA, INVOKAMET/XR	FARXIGA, JARDIANCE, SYNJARDY, SYNJARDY XR, XIGDUO XR
Test Strips	ONETOUCH ULTRA, ONETOUCH VERIO	ACCU-CHEK brand strips, kits, and lancets
Thyroid Agents	TIROSINT	levothyroxine, SYNTHROID
Topical Acne	ACANYA, BENZACLIN, ONEXTON, VELTIN, ZIANA	adapalene, clindamycin-benzoyl peroxide, ATRALIN, DIFFERIN, EPIDUO, RETIN-A MICRO, TAZORAC

New Formulary Additions/Tier Changes

Class	Product
Autoimune	XELJANZ, XELJANZ XR[P]
Growth Hormone	GENOTROPIN[P]
Sodium-Glucose Co-transporter 2 (SGLT2) Inhibitors and Combination Products	ARDIANCE[P], SYNJARDY[P], SYNJARDY XR[P], GLYXAMBI[P]
Test Strips	ACCU-CHEK[P]

NP = Non Preferred drug being added back **P = Preferred drug being added back**

2019 Metallic Formulary removals and updates

Therapy classes with drug removals and updates for 2019

New Formulary Exclusions

Class	Product	Preferred Alternatives
Antiemetic	EMEND suspension	aprepitant capsules
	ZUPLENZ	ondansetron, granisetron, SANCUSO
Anthelmintic	ALBENZA	Contact prescriber
Antiretroviral	ATRIPLA	BIKTARVY, SYMFI, SYMFI LO, COMPLERA, ODEFSEY, STRIBILD, TRIUMEQ, GENVOYA
Autoimmune	CIMZIA, ORENCIA	COSENTYX, ENBREL, HUMIRA, KEVZARA, XELJANZ, XELJANZ XR, OTEZLA, STELARA, TALTZ
Biguanides	metformin ER 750, 1000 (generic FORTAMET)	metformin ER (generic GLUCOPHAGE ER 500mg and 750mg)
Cardiovascular	PRALUENT	REPATHA
	CORLANOR	Contact prescriber
DPP4 and biguanide combinations	JENTADUETO XR, ONGLYZA	alogliptin, JANUVIA, JANUMET XR, JENTADUETO XR
Genitourinary	phenazopyridine	OTC phenazopyridine, Consult Physician
Growth hormone	GENOTROPIN, NORDITROPIN, OMNITROPE	HUMATROPE
Hematologic agents	JADENU	FERRIPROX
	NEULASTA	FULPHILA
	PROCRIT	RETACRIT
Hormones/hormone modifiers	LUPRON DEPOT	LUPANETA PACK, SYNAREL
	SANDOSTATIN LAR	octreotide
	SEROSTIM	dronabinol, megestrol
Insulin	APIDRA, HUMALOG, HUMALOG KWIKPEN	NOVOLOG, FIASP

Class	Product	Preferred Alternatives
Incretin mimetics	BYDUREON	TRULICITY, VICTOZA, OZEMPIC
Inhalers: anticholinergic	TUDORZA	INCRUSE ELLIPTA, SPIRIVA
Inhalers: beta-agonist	BROVANA, ARCAPTA, SEREVENT	STRIVERDI RESPIMAT
Inhalers: anticholinergic/beta agonist combinations	ANORO	BEVESPI
Non-steroidal anti-inflammatory drugs	naproxen suspension, naproxen 275mg, naproxen 550mg	naproxen 250mg, naproxen 500mg
Musculoskeletal	tizanidine capsules	tizanidine tablets
Ophthalmic drugs	CILOXAN, TOBREX	ciprofloxacin solution, gatifloxacin, levofloxacin, moxifloxacin, Besivance, gentamicin ointment, erythromycin ointment
Opioid analgesics	PRIMLEV	oxycodone/acetaminophen, hydrocodone/acetaminophen
Osteoporosis	FORTEO	TYMLOS, PROLIA
Sodium-glucose co-transporter 2 (SGLT2) inhibitors and combination products	INVOKANA, INVOKAMET, INVOKAMET XR	JARDIANCE, FARXIGA, SYNJARDY, SYNJARDY XR, XIGDUO XR
Test strips/lancets	ONE TOUCH ULTRA, ONE TOUCH VERIO	ACCU-CHEK test strips and lancets
Topical: acne	ACANYA	tretinoin, benzoyl peroxide, adapalene, clindamycin/benzoyl peroxide
Topical: other	CAPEX, TEXACORT	fluocinolone solution
	CORDRAN, DESONATE, VERDESO	clobetasol, halobetasol, desonide
	KERYDIN	terbinafine, itraconazole, JUBLIA
	OTOVEL	ofloxacin

Tier Increases

Product	Change
adefovir, entecavir	Tier 5

Product	Change
AUBAGIO, BETASERON, COPAXONE, GILENYA, REBIF, TECFIDERA	Tier 5
Cyclophosphamide, irinotecan, oxaliplatin, gemcitabine	Tier 5
calcipotriene, calcipotriene/betamethasone	Tier 4
JENTADUETO XR	Tier 4
PROMACTA	Tier 6
tobramycin	Tier 5
voriconazole	Tier 4
XYREM	Tier 5
zileuton ER	Tier 4

New Utilization Management Changes

Product	Change
EMSAM	Add PA
EMVERM	Add QL
FETZIMA, SAVELLA	Add ST
TRUVADA	Add ST/PA
NUEDEXTA	Add PA
lidocaine 5% patches	Add PA
OMNARIS	Add ST
REGRANEX, SANTYL	Add PA
vancomycin	Remove ST; Add QL
JANUVIA, JANUMET, JANUMET XR FARXIGA, VICTOZA, TRULICITY, XIGDUO XR, TRADJENTA, QTERN	Add ST
Product	**Change**
tacrolimus, ELIDEL	Term ST
LIVALO, Rosuvastatin	Add ST

New Formulary Additions/Tier Changes

Class	Product
Autoimmune	TALTZ[P], XELJANZ XR[P]
Antiemetic	SANCUSO[P]

Class	Product
Antineoplastic	KISQALI[P], ODOMZO[P]
Antiretroviral	BIKTARVY[P], CIMDUO[P], SYMFI[P], SYMFI LO[P], TROGARZO[P]
Incretin Mimetic Combinations	SOLIQUA[P], XULTOPHY[NP]
Hematologic	RETACRIT[P], FULPHILA[P]
Osteoporosis	TYMLOS[P]
Sodium-Glucose Co-transporter 2 (SGLT2) Inhibitors and Combination Products	GLYXAMBI[P], SYNJARDY[P], SYNJARDY XR[P]
Respiratory	GLASSIA[P], PROLASTIN-C[P] NUCALA[P], XOLAIR[P]
Test Strips/Lancets	ACCU-CHEK[P]
Topical	EUCRISA[P]

NP = Non Preferred drug being added back P = Preferred drug being added back

2018 Open Enrollment: Please Use AHIN

2018 Open Enrollment periods began on October 1, 2018, and will continue through December 15, 2018. The enrollment of many new members and current member renewals are producing extremely high call volumes, which is expected to remain through January 31, 2019. Arkansas Blue Cross and Blue Shield strongly encourages provider offices and facilities to use the Advanced Health Information Network (AHIN) website for verifying eligibility, benefits and claims status. AHIN displays information on benefits to assist providers when scheduling appointments, checking eligibility and identifying benefits. Arkansas Blue Cross is planning and staffing to answer a higher call volume, but call volumes can spike and exceed our ability to answer every call. AHIN uses the same information available to our customer service representatives and can save you valuable time.

2019 Changes to the Arkansas Works Program

More changes are coming to Arkansas Works work-requirement program in 2019. Beginning in January 2019, the Arkansas Department of Human Services (DHS) will implement Phase II of the work requirement plan, which requires enrollees to work, volunteer or do job training for 80 hours per month to keep their Arkansas Works plan. Here's who is affected in Phase II:

- Enrollees ages 19-29. Phase I was individuals age 30-49.
- Enrollees below 138 percent of federal poverty level (FPL). Phase I included only enrollees below 100% of FPL.

Not everyone's work requirement will begin at the same time. Some members will have to start reporting in January 2019. DHS will send members a notice explaining when their work requirement begins.

It is important for Arkansas Works members to report their work each month. **If they fail to report their work for any three months in a year, they will lose their Arkansas Works health insurance coverage for the year.**

How can providers help?

Physicians and hospital systems can check the Advanced Health Information Network (AHIN) each month to see if their Arkansas Works patients have reported their work activity. Pharmacists will receive notifications through the OutcomesMTM® platform (medication therapy management). Providers can help Arkansas Works members keep their coverage by explaining how to report their work activity each month. If a patient is at risk of not complying with the work requirement and needs more information, please have them contact Arkansas Blue Cross at 1-800-800-4298 for assistance. If patients need help reporting their work each month, an Arkansas Blue Cross and Blue Shield representative can act as their registered reporter.

Need more information? Visit arkbluecross.com/arkansasworks or call 1-800-800-4298.

Coverage Policy Manual Updates

Since October 2018, policies were added or updated in Arkansas Blue Cross and Blue Shield's Coverage Policy manual. The table highlights these additions and updates. To view entire policies, access the coverage policies located on our website at arkansasbluecross.com.

Policy ID#	Policy Name
1997014	Autologous Chondrocyte Implantation for Focal Articular Cartilage Lesions
1997026	Blepharoplasty/Blepharoptosis
1997105	Interferon Gamma-1B
1997113	Immune Globulin, Intravenous and Subcutaneous
1997254	Vacuum Assisted Closure Device
1998155	Respiratory Syncytial Virus, Immune Prophylaxis with Palivizumab (Synagis)
1998158	Trastuzumab
1998168	Etanercept (Enbrel)
2003020	Hysteroscopic Placement of Micro-Inserts in the Fallopian Tubes as a Form of Permanent Sterilization
2005027	Subconjunctival Retinal Prosthesis
2006006	Osteochondral Allograft and/or Mosaicplasty for Osteochondral Defects of the Knee
2006026	Genetic Test: Cerebral Autosomal Dominant Arteriopathy with Subcortical Infarcts & Leukoencephalopathy (CADASIL) (NOTCH3)
2006027	Dynamic Spinal Visualization and Vertebral Motion Analysis

Policy ID#	Policy Name
2009013	Testing for Drugs of Abuse or Drugs at Risk of Abuse Including Controlled Substances
2009044	Vagus Nerve Stimulation
2009047	Hormone Pellet Implantation for Hormone Replacement Therapy
2011006	Ipilimumab (Yervoy™)
2011039	Preventive Services for Non-Grandfathered (PPACA) Plans: Hepatitis B Virus Infection Screening in Pregnancy and Asymptomatic Adolescents and Adults
2011053	Autism Spectrum Disorder, Applied Behavioral Analysis
2011054	Autism Spectrum Disorder, Other Interventions
2011066	Preventive Services for Non-Grandfathered (PPACA) Plans: Overview
2012022	PET or PET/CT for Urological Cancers
2012027	PET Scan for Multiple Myeloma, Plasmacytoma
2012034	Preventive Services for Non-Grandfathered (PPACA) Plans: Human Papillomavirus (HPV), Screening for Sexually Active Women
2012035	Preventive Services for Non-Grandfathered (PPACA) Plans: Contraceptive Use and Counseling
2012038	Preventive Services for Non-Grandfathered (PPACA) Plans: Lead Screening in Infants and Children Through Age Six
2012045	Preventive Services for Non-Grandfathered (PPACA) Plans: Autism Screening
2012058	PET or PET/CT for Small Cell Lung Cancer
2012062	Radiofrequency Ablation of Primary or Metastatic Liver Tumors
2012068	Genetic Test: Preconception or Prenatal Testing as a Carrier Screen
2013015	Treatment of Varicose Veins/Venous Insufficiency
2013023	Preventive Services for Non-Grandfathered (PPACA) Plans: Hepatitis C Virus Screening
2013032	Hereditary Angioedema (HAE), Prophylaxis and Acute Treatment
2016005	Anti-PD-1 (programmed death receptor-1)Therapy (Pembrolizumab)(Nivolumab)(Durvalumab)

Data Required on CMS1450 (UB04) Facility Claims Submitted for Secondary Payment

Arkansas Blue Cross and Blue Shield and its affiliated companies will no longer be able to manually process facility claims submitted on paper with incorrect or incomplete information in the payer fields (boxes 50, 56, and 57) and the patient fields (boxes 58, 59, and 60).

Any time providers are filing for secondary payment on the UB04, complete information about the payer from whom the provider is seeking payment should always be filed in line 50A with

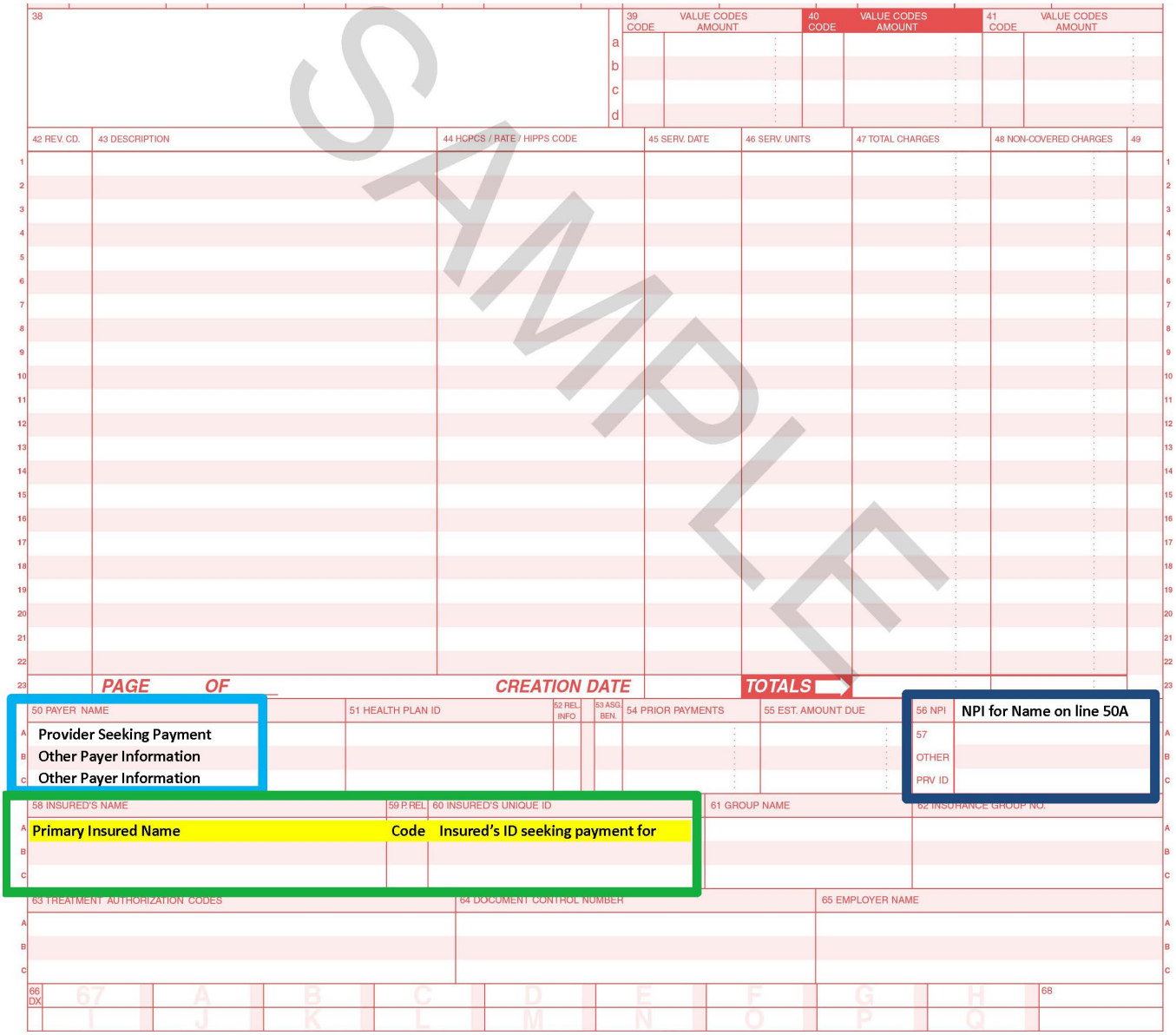
the Explanation of Benefits attached. All other payer information should be filed in 50B and 50C. Payment will always be made to the payer that is in line 50A. **If the claim does not have complete and accurate information, the claim will be returned to the provider.**

Arkansas Blue Cross is able to accept electronic submissions for secondary payment and would prefer that claims be sent in this medium. Providers are encouraged to submit claims electronically for all Arkansas Blue Cross lines of business.

With the implementation of the national coordination of benefits process for Medicare, it is unnecessary to submit claims to Arkansas Blue Cross for secondary payment for Medicare primary claims. Arkansas Blue Cross asks that providers not send paper claims for payment secondary to Medicare until at least 30 days after the primary payment is made by Medicare.

If after 30 days, a secondary payment has not been received from Arkansas Blue Cross, providers can confirm that Arkansas Blue Cross has received the crossover in the AHIN system. If providers see the claims in AHIN, there is no need to file paper for secondary payment.

The image below is a sample of the UB04 form with box indicators for the requests above.



Fighting the opioid epidemic in Arkansas

Arkansas Blue Cross and Blue Shield and the larger Blue Cross and Blue Shield system have made progress toward preventing inappropriate prescription opioid use. But the opioid epidemic remains a critical health crisis in the state and country.

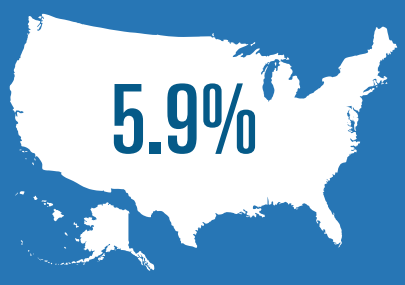
Decrease in opioid prescriptions statewide

(Percent change in opioid prescriptions per 1,000 Blue Cross and Blue Shield members, 2013-2017)

-27%
CHANGE IN OPIOID PRESCRIPTIONS **FOR ARKANSAS** GROUP MEMBERS

(Per 1,000 members)

As we continue to fight opioid use disorder in Arkansas, **5.1 per 1,000** Blue Cross and Blue Shield members are diagnosed. That's below the national average of **5.9 per 1,000**.



39% **DECREASE IN** OPIOID QUANTITY DISPENSED

Opioid use disorder prevention

Arkansas Blue Cross and Blue Shield Pharmacy is fighting opioid addiction. We use our medical, pharmacy and data management tools to monitor and prevent over-prescribing and diversion of prescription opioids and other controlled substances. It's just one way we're helping keep our members safe and healthy.

Questions?

Contact your Arkansas Blue Cross representative to learn more about how we're safeguarding Arkansans from opioid use disorder.

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What we're doing at Arkansas Blue Cross

At Arkansas Blue Cross, we're taking steps to cut down on substance-use disorder. We provide case management, behavioral health and medication-assistance treatment support for members who have our pharmacy benefits and additional help for those with case management.
Here are some of the initiatives we've taken.

Quality of care programs

- Hired substance-use prevention coordinator
- Communicate with prescribers about patients on drug combinations that could produce overdose
- Case manage members who meet certain thresholds

Quantity limits/utilization management/plan design

- Limit to 7-day fills for acute pain patients
- Decrease quantity limit for chronic pain patients (more closely match CDC guidelines)
- Require patients to use immediate-release opioids first before moving to extended release
- Removed the prior authorization from Suboxone™
- Removed member cost-share from naloxone on fully-insured business

Network initiatives

- Provide reporting around opioids to collaborative heath and other physician group partners
- Required registration with the PDMP for physicians to be in the network

Blue & You Foundation for a Healthier Arkansas grants

- Provided a grant to help police officers have naloxone
- Provided a grant to fund prescriber education

Arkansas Blue Cross will remain focused on new, effective ways to fight this national crisis and reduce opioid dependency with our membership.

Questions?

Contact your Arkansas Blue Cross representative to learn more about how we're safeguarding Arkansans from opioid use disorder.

This report builds upon and provides updated results on a previously published BCBS Health of America report from 2017 entitled, "America's opioid epidemic and its effect on the nation's commercially-insured population." It is based on the prescription and medical claims of over 41 million commercially insured BCBS members. In this report, "opioids" include prescription opioid medications. Members diagnosed with cancer who were undergoing palliative or hospice care were excluded from this analysis. For more information on how BCBS is addressing America's opioid epidemic, see: **https://www.bcbs.com/the-health-of-america/addressing-americas-opioid-addiction**

The Centers for Disease Control and Prevention (CDC) reports that, on average, 115 Americans die each day from an opioid-related overdose. Further, the CDC cites that of those 115 deaths, about 46 people die per day from overdoses linked to prescription opioid medications. For more information, see: **https://www.cdc.gov/drugoverdose/epidemic/index.html**, **https://www.cdc.gov/drugoverdose/data/overdose.html** and **https://wonder.cdc.gov/**

Arkansas Blue Cross Pharmacy data shows the total dispensed unit quantity of opioids has decreased 37% from January 2015 through March 2018.

All tips and advice here are recommended by the U.S. Food & Drug Administration (FDA). The FDA provides helpful resources to raise awareness of opioid use and addiction. Information above is found within the BCBSA study that examines opioid prescription rates, opioid use patterns and opioid use disorder among commercially insured BCBS members.

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An Independent Licensee of the Blue Cross and Blue Shield Association

Arkansas State Employee/Public School Employee Medical Plan Changes

Effective January 1, 2019, Health Advantage will become the third-party administrator for all medical/health plans under the Employee Benefits Division (EBD) – including Medicare Primary members. In addition, Health Advantage will administer the:

- Medical management programs
- Precertification/Preauthorization program – same inpatient and outpatient service requirements
- Preauthorization program – including high-tech radiology through AIM and behavioral health through New Directions

EBRx (pharmacy) will continue to administer prior authorizations for medical specialty drugs. Please contact EBRx at 1-855-757-9526

There are no benefit coverage eligibility changes. There are changes to the Public School Employees' plan deductibles. Deductible information can be found on the Advanced Health Information network (AHIN).

Approximately 27,000 Medicare Primary retirees will receive new member ID cards that will be effective January 1, 2019. The new ID cards will have a prefix of "PXGY00" for the member ID number.

Effective January 1, 2019, Arkansas State Employee and Public School Employee plans for members in central Arkansas will be subject to "withhold" for claims processing.

The EBD provider services phone number remains the same: **1-800-482-8416**.

Federal Employee Program Once-per-Lifetime Self-Administered Injectable Drugs

Effective for services incurred on or after January 1, 2017, benefits are limited to once per lifetime when the following drug procedures are dispensed/provided by a physician healthcare professional or hospital.

Drug Code Group	HCPCS Procedure Codes
Auto-immune drugs	J0135, J1438, J2793, J3357
Multiple sclerosis drugs	J1595, J1830, J1826, Q3027, Q3028
Growth hormones	J2170, J2941
Others	J0364, J0800, J1324, J1744, J3110, J9216

Federal Employee Program Blue Focus Product Offering

Blue Focus is a new product offering for FEP, in addition to Basic and Standard Options. The breakdown of benefits in the table below is an overview of services.

Common services at preferred providers	Copay/Deductible
Primary care provider	$10 per visit for your first 10 primary and/or specialty care visits
Specialists	$10 per visit for your first 10 primary and/or specialty care visits
Virtual doctor visits	$0 first 2 visits/$10 all additional visits – Vendor: Teledoc
Urgent care centers	$25 copay
Maternity	$0 for doctor visits/$1,500 for facility care
Inpatient hospital	30% of local plan allowance
Outpatient hospital	30% of local plan allowance
Surgery	30% of local plan allowance
ER (accidental injury)	$0 within 72 hours
ER (medical emergency)	30% of local plan allowance
Lab work (lab tests and EKGs)	30% of local plan allowance
Diagnostic Services (sleep studies, X-rays, CT scans)	30% of local plan allowance
Chiropractic care	$25 for up to 10 visits a year
Deductibles	Out-of-Pocket Maximum (preferred providers)
Self only - $500	Self only - $6,500
Self + one and self + family - $1,000	Self + one and self + family - $13,000
List of Services requiring Prior Approval (PA) **Failure to obtain PA will result in a $100 penalty. Precertification is also required if the service or procedure requires an inpatient hospital admission.*	
Air ambulance transport (non-emergent) – air ambulance transport related to immediate care of a medical emergency or accidental injury does not require PA.	
Applied behavior analysis (ABA) – prior approval is required for ABA and all related services, including assessment, evaluations and treatments.	
Blood or marrow stem cell transplants	
Cardiac rehabilitation	
Clinical trials for certain blood or marrow stem cell transplants	
List of Services requiring Prior Approval (PA) Continued	

**Failure to obtain PA will result in a $100 penalty. Precertification is also required if the service or procedure requires an inpatient hospital admission.*
Cochlear implants
Gene therapy and cellular immunotherapy including Car-T and T-cell receptor therapy.
Genetic testing including the following: (BRACA screening or diagnostic testing, large genomic, rearrangements of BRCA and BRCA2 genes screening or diagnostic testing, genetic testing for the diagnosis and /or management of an existing medical condition.
Hospice care
IMRT
Organ/tissue transplants: Benefits for certain transplants are limited to designated transplant center or programs. However, the following types of transplants are not available in a Blue Distinction Center for Transplants and must be performed at a preferred facility with a Medicare-approved transplant program for the type of transplant anticipated if Medicare has an approval program for the type of transplant: kidney-only, intestinal, pediatric pancreas, pediatric lung and heart-lung transplants.
Outpatient residential treatment center care
Prosthetic devices (external)
Pulmonary rehabilitation
Radiology high technology including MRI, CT and PET
Specialty durable medical equipment (DME)
Surgical services, such as morbid obesity, gender reassignment surgery, outpatient surgical correction of congenital anomalies, oral maxillofacial surgeries/surgery on the jaw, tongue, floor and roof of the mouth, and related procedures, orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint, orthopedic procedure, reconstructive surgery for conditions other than breast cancer, rhinoplasty, septoplasty varicose vein treatment.
Transplants – Approval is required for all transplants, except cornea and kidney. PA is required for both the procedure and if benefits require, the transplant program; precertification is required for inpatient care.

*Warning: Benefits will be reduced by $100 for medically necessary services that require PA, if providers fail to obtain prior approval. If the services are not medically necessary, Arkansas Blue Cross will not provide the benefits. This benefit reduction does not apply to prescription drugs requiring prior approval.

Outpatient PAs can be submitted by completing the prior approval request form available on our website at www.arkansasbluecross.com/providers/AuthServices.aspx by selecting the "Prior Approval form" link, or contacting FEP Customer Service at 800-482-6655 or 501-378-2531 (Monday – Friday, 8 a.m. – 5 p.m.) and following the prompts for the Prior Approval Department. In addition, inpatient prior approvals can only be submitted by contacting FEP Customer Service staff (Monday – Friday 8 a.m. – 5 p.m.) or at 800-482-6655 or 501-378-2531 and following the prompts for inpatient admissions.

Federal Employee Program Standard and Basic Option Benefit Changes for 2019

Basic Option Changes

Sleep Studies

- Sleep study copayment will now be $40 regardless of the place of service.

1. The following sleep study procedure codes will be considered eligible home-based sleep studies when billed by professional or outpatient facility providers; they will no longer require approval, and will be removed from compatibility edit C4D:

   - **95800**: Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (e.g., by airflow or peripheral arterial tone), and sleep time
   - **95801**: Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (e.g., by airflow or peripheral arterial tone
   - **95806**: Sleep study, unattended, simultaneous recording of heart rate, oxygen saturation, respiratory airflow, and respiratory effort (e.g., thoracoabdominal movement

2. Preferred outpatient facility-billed claims for the following sleep study procedure codes will apply a $40 copayment for basic option members (provided there are no other services included on the claim that require a higher outpatient facility copayment amount):

   - **95800**
   - **95801**
   - **95806**
   - **G0398:** Home sleep study test (HST) with type ii portable monitor, unattended; minimum of seven channels: eeg, eog, emg, ecg/heart rate, airflow, respiratory effort and oxygen saturation
   - **G0399:** Home sleep test (HST) with type iii portable monitor, unattended; minimum of four channels: two respiratory movement/airflow, one ecg/heart rate and one oxygen saturation
   - **G0400:** Home sleep test (HST) with type iv portable monitor, unattended; minimum of three channels

Standard and Basic Option Changes

Preventive Care

- Adult preventive care benefits for tetanus, diphtheria and pertussis booster will be unlimited. Previously, benefits were limited to one every 10 years.

- Pathology services associated with preventive colonoscopies and sigmoidoscopies will now be covered under preventive care benefits.

Surgery

- Benefits will be provided for bariatric surgery for members who have a diagnosis of morbid obesity for a period of one year prior to surgery. Previously the waiting period was two years.

Non-member Facility Charges

- Payment for non-emergency (routine maternity) deliveries will be based on the plan allowance and emergency (maternity) deliveries will be based on the billed amount when services are performed at a non-participating hospital or other facility.
- Payment for non-emergency outpatient services at a non-participating facility will be based on the plan allowance.
- Emergency medical services performed in a non-participation emergency room will now use the plan allowance instead of the UCR (usual, customary and reasonable) amount.

Gender Reassignment

- Benefits are now allowed for electrolysis (hair removal) as part of the preparation for gender reassignment surgery.
- Candidates for gender reassignment surgery are required to be under the care of a mental health professional for a minimum of 12 months prior to treatment.

Acupuncture

- Acupuncture services billed by a facility will now accumulate to the member's annual limit (24 visits per calendar year for standard option and 10 visits per calendar year for basic option) except when performed as an anesthesia service.

Drugs

- Medical benefits will be provided for infusion medication Remicade and its two biosimilars, Renflexis and Inflectra.

Telehealth

- Telehealth benefits for services related to dermatology care (diagnosis, treatment and prevention of diseases of the skin, hair, nails and body) will be provided.

Prior Approval

- Prior approval will now be required for all non-emergent air ambulance transports.
- Gene therapy and cellular immunotherapy services, (e.g. Car-T and T-cell receptor therapy) will now require prior approval.

Unattended sleep studies (95800, 95801 and 95806) will no longer require prior approval regardless of place of service.

New Federal Employee Program Opioid Prescription Requirements

The Federal Employee Benefit Plan has implemented a Risk Evaluation and Mitigation Strategy (REMS) for any prescriber of extended-release and long-acting opioids. This requirement is effective immediately, based on the federal Food and Drug Administration (FDA) communique in September 2018 about opioid analgesic prescribing.

The following link will direct the user to the REMS program: www.er-la-opioidrems.com/IwgUI/rems/home.action.

Prescribers will be required to complete a continuing education activity and agree to counsel their patients when prescribing opioids. Prescribers then will be required to attest on the prior approval form that he/she has completed the REMS requirements. Failure to complete the REMS activity will result in denial of the opioid prescription.

For more information about the FDA's September 2018 REMS communique, please click on the following links:
www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm163647.htm
www.fda.gov/downloads/Drugs/DrugSafety/InformationbyDrugClass/UCM620249.pdf

What You Should Know About CAHPS and HOS Quality Measures

You can make a difference

What are CAHPS and HOS?

Each year, the federal Centers for Medicare & Medicaid Services (CMS) and the Federal Employee Program (FEP) measure patient satisfaction, experience and outcomes for Arkansas Blue Cross and Blue Shield's Medicare Advantage (MA) plans, Affordable Care Act (ACA) plans (including Arkansas Works) and Federal Employee Plans. These member surveys usually are referred to as CAHPS (Consumer Assessment of Healthcare Providers and Systems) and HOS (Health Outcomes Survey).

- CAHPS:
    - This survey measures the patient experience with health plans, providers and healthcare facilities.
    - The survey is administered between March and June for MA & ACA plans and quarterly for FEP plans.
    - More information may be found at MA-PDPCAHPS.org.

- HOS:
    - This survey measures patient-reported health outcomes and assesses the ability of a Medicare Advantage organization to maintain or improve the physical and mental health of its members over time. It is not used for FEP members.
    - The survey is administered between April and July.
    - More information may be found at hosonline.org.

How Can CAHPS and HOS Help Your Practice?

Arkansas Blue Cross and providers share a common goal: highly satisfied patients/members. Practices will benefit because patients who are highly satisfied are more loyal, more likely to adhere to treatment plans and enjoy healthier, happier and more productive lives. Everyone deserves to live life fully, so use this brief guide on recommendations you can implement year-round to increase your patient satisfaction.

Recommendations for Improving CAHPS and HOS Measures

Survey Name and Measure	Survey Question to Patient	Recommendation to Provider Where Applicable
CAHPS: Annual flu vaccine	Have you had a flu shot since July 1, 2018?	Administer flu shot after July 1, 2018 and before February 1, 2019.
CAHPS: Getting appointments and care quickly	In the last six months: • How often did you see the person you came to see within 15 minutes of your appointment time? • When you needed care right away, how often did you get care as soon as you thought you needed it? • Not counting the times when you needed care right away, how often did you get care as soon as you thought you needed it?	• If you are behind schedule, establish an office protocol to update waiting patients. Often, they are more accepting if they are given a chance to reschedule, see a different provider or know the reason for the delay. • Break up wait times by moving patients from the waiting room into an exam room to take vitals. • Apologize to patients for delays to acknowledge that you value their time. • Keep a few appointments open each day for urgent visits, including post-inpatient discharge visits. • Offer appointments with a nurse practitioner or physician's assistant to patients who want to be seen on short notice. • Ask patients to make routine checkup and follow-up appointments in advance.

Survey Name and Measure	Survey Question to Patient	Recommendation to Provider Where Applicable
CAHPS: Overall rating of healthcare quality	Using any number between zero and 10, where zero is the worst healthcare possible and 10 is the best healthcare possible, what number would you use to rate all your healthcare in the past six months?	During the visit, ask your patients how they think you could improve their healthcare. Asking this question can: • Build trusting relationships between you and your patients. • Give your patients the opportunity to discuss positive interactions that you can relay to your staff. • Provide ideas for opportunities to improve upon, if negative feedback is given.
CAHPS: Care coordination	• When you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care? • When your personal doctor ordered a blood test, X-ray or other test for you, did someone from your personal doctor's office follow up to give you those results? • Did your personal doctor talk to you about all the prescription medicines you were taking? • Did you get the help you needed from your personal doctor's office to manage your care among these different providers and services? • How often did your personal doctor seem informed and up to date about specialist care?	• Before walking in the exam room, read the current complaints and determine if anything needs a follow-up from previous visits. • When ordering tests, let your patients know when they can expect results. Implement a system to ensure timely notifications of results. • Ask your patients if they saw another provider since you last met with them. If you know patients received specialty care, discuss their visit and whether the specialist prescribed any additional medication.

HOS: Improving or maintaining physical health	• During the past four weeks, has pain stopped you from doing things you want to do?
	• Have you had any of the following problems with your work or other regular daily activities because of your physical health?
	  ○ Accomplished less than you would like
	  ○ Didn't do work or other activities as carefully as usual
		• Thoroughly evaluate the cause of pain and the current treatment plan.
		• Identify ways to improve the pain problem.
		• Determine if your patients could benefit from a consultation with a pain specialist or rheumatologist.
		• Consider physical therapy or cardiac or pulmonary rehabilitation, when appropriate.

Survey Name and Measure	Survey Question to Patient	Recommendation to Provider Where Applicable
HOS: Improving or maintaining mental health	Have you had any of the following problems with your work or other regular daily activities because of emotional problems? • Accomplished less than you would like • Didn't do work or other activities as carefully as usual • Didn't have a lot of energy or felt sad or depressed most days	• During the visit, include emotional wellness in your assessment. • Empathize with patients. • Encourage ideas to improve mental wellness (e.g., exercise, socialization, pet interaction, staying involved with family). • Consider therapy with a mental health professional when appropriate. • Consider a hearing test when appropriate, as loss of hearing can be isolating.
HOS: Monitoring physical activity	In the past 12 months, did: • You talk with a doctor or other healthcare provider about your level of exercise of physical activity? • A doctor or other healthcare provider advise you to start, increase or maintain your level of exercise or physical activity?	• Discuss appropriate physical activity with your patients and offer suggestions based on their ability. • Offer ideas for where patients can go to enjoy a variety of exercise options. These also offer opportunities for social interaction.
HOS: Improving bladder control	• In the past six months, have you accidentally leaked urine? • How much of a problem, if any, was the urine leakage for you? • Have you received other treatments for your current leakage problem?	• Regularly integrate the sensitive conversation about bladder control into your conversations with your patients. • When talking to patients, note that urinary leakage problems can be common as we grow older, but there are treatments that can help. This opens the conversation if they are too embarrassed to bring it up. • Do they have leakage problems? Regardless of the frequency or severity of the problem, discuss potential treatments options, such as medications, exercises and surgery.

Centers for Medicare and Medicaid Services Preclusion List

The Final Rule issued by the Centers for Medicare and Medicaid Services (CMS) on April 16, 2018[1], rescinded the Medicare enrollment requirement for contracted providers that receive payment from Medicare plans[2], 1876 Cost Plans or PACE organizations. Additionally, CMS rescinded the requirement that providers who prescribe drugs enroll in Medicare in order for the prescriptions they write to be covered under Part D.

Alternatively, the Final Rule adopted a requirement that, in order for contracted and non-contracted providers to receive payment from a Medicare plan, 1876 Cost Plan, or PACE organization for health care items and services furnished to beneficiaries such providers must not be included on the Preclusion List. Likewise, in order for Part D drugs to be covered by a Part D plan, the prescriber must not be included on the Preclusion List.

CMS provided guidance regarding the Preclusion List requirements to plans on November 2, 2018.

What is the Preclusion List?

The Preclusion List will consist of providers (can be either individuals or entities) that fall into one of two categories. The categories are:

(1) Are currently revoked from Medicare, are under an active reenrollment bar, and CMS determines that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or

(2) Have engaged in behavior for which CMS could have revoked the individual or entity to the extent applicable if they had been enrolled in Medicare and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program.

Before providers are added to the Preclusion List, they will be notified by CMS of their potential inclusion and applicable appeal rights. CMS will add a provider to the Preclusion List only if the provider's appeal is denied at the CMS level or the timeframe to request an appeal at the CMS level has expired.

There will be one Preclusion List with subsequent periodic updates. The updates will be made approximately every 30 days around the first business day of each month. The initial list will be made available to Medicare and Part D plans on January 1, 2019, via secure website. There is a guide entitled "Access to CMS Preclusion List Quick Reference Guide" that provides instructions for accessing located on the CMS website[3].

[1] CMS-4182-F

[2] Medicare Advantage (MA), 1876 Cost Plans, or Programs of All-Inclusive Care for the Elderly (PACE) organizations for health care items and services furnished to Medicare beneficiaries enrolled in MA or MA-PD plans

[3] https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/PreclusionList.html

What are the requirements for Medicare Plans?

Medicare plans and Part D plans should begin reviewing the Preclusion List as soon as possible beginning January 1, 2019, but no later than January 31, 2019. Plans should continue to review the Preclusion List on a regular basis going forward.

Medicare plans and Part D plans should remove any contracted provider who is included on the Preclusion list and/or any precluded pharmacy from their network as soon as possible. Plans are required to notify those enrollees who have received care within the last 12 months from a contracted provider or who have received a prescription from a provider who is included on the Preclusion List as soon as possible.

CMS has recommended that for 2019, Plans furnish Medicare beneficiaries with at least 60 days' advance notice before the plan begins: 1) denying payment for a health care item or service furnished by a precluded provider; and/or 2) rejecting a pharmacy claim or denying a beneficiary request for reimbursement for a drug prescribed by a precluded provider. CMS suggests that payment denials and claims rejections begin on April 1, 2019, for the January 1, 2019, Preclusion List. This allows 30 days for plans to review the Preclusion List and notify the beneficiaries no later than 30 days from the posting for the list while allowing an additional 60-day period for the beneficiaries to prepare. **Medicare plans and Part D plans may not reimburse or make payment for claims or prescriptions associated with any providers on the initial Preclusion List for dates of service on or after April 1, 2019, including for emergency or urgent care circumstances.**

CMS recommends that plans follow the same process for monthly updates as they did for the initial list. This means plans will have 30 days to review the Preclusion List for updates and should then notify the affected beneficiaries no later than 30 days from the posting of the updated list. The affected beneficiaries should then be given at least 60-days' advance notice before payment denials and claims rejections begin. Plans may notify included providers by copying them on the notice sent to the enrollee or by other means.

It is important to note that the Preclusion List does not replace credentialing and provide oversight requirements or eliminate plan responsibility to validate that providers are not included on the Office of Inspector General (OIG) exclusion file.

Requirements for Medicare Outpatient Observation Notice

In compliance with the Centers for Medicare and Medicaid Services (CMS) Medicare Outpatient Observation Notice (MOON), Arkansas Blue Cross and Blue Shield requires all acute care and critical access hospitals to provide written notification and an oral explanation of the notification to patients receiving outpatient observation services for more than 24 hours. The notice must be delivered no later than 36 hours after observation services begin. For Medi-Pak® Advantage members, any observation stays require pre-authorization or pre-notification requirements.

The notice should explain the following using contemporary language:

- The patient is classified as outpatient, not an inpatient of the hospital
- The reason for receiving observation services
- Cost-sharing requirements
- Medication coverage
- Subsequent eligibility for coverage of services furnished by a skilled nursing facility
- Advise patients to contact his or her insurance plan with specific benefit questions

The notice and accompanying instructions are available on our website at arkansasbluecross.com/providers/forms.aspx or on the CMS Beneficiary Notices Initiative page at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html.

Centers for Medicare and Medicaid Services Enforces Medi-Pak® Advantage Provider Directory Accuracy

Maintaining accurate provider information is critically important to ensure that consumers have timely access to care. Updated information helps us maintain accurate provider directories and also ensures that providers are more easily accessible to our members. Additionally, plans are required by Centers for Medicare & Medicaid Services (CMS) to list accurate information in provider directories for certain key data elements. Accuracy of online and printed provider directories are routinely audited by CMS.

Since it is the responsibility of each provider to inform plans when there are changes, providers are reminded to notify Arkansas Blue Cross of any changes to their demographic and other information. This includes a change in a provider's ability to accept new patients, street address, phone number or any other change that has the potential to affect patient access to care. For Arkansas Blue Cross to remain compliant with federal and state requirements, changes must be communicated within 30 days so that members have access to the most current information in the Provider Directory.

Key Data Elements

The data elements required by CMS and crucial for member access to care are as follows:
- Physician Name
- Location (i.e. Clinic Name, Address, Suite, City/State, Zip Code) If in several locations, specify the primary location and ensure all Clinic Names are accurate
- Phone Number (for each clinic provider practices, if in several locations)
- Specialties
- Accepting New Patient Status (for each clinic provider practices, if in several locations)
- Hospital Affiliations
- Medical Group Affiliations

How to Update Information

You should routinely check your current practice information by going to www.arkansasbluecross.com and select "**Find Care**" or use this link: arkansasbluecross.com/healthcare-providers/#/ChooseNetwork. If your information is not correct and updates are needed, please provide the correct information as soon as possible by completing the **Provider Change of Data** form located at www.arkansasbluecross.com/providers/forms.aspx. You also may receive a data verification letter from Provider Network Operations to provide an additional opportunity to confirm your information.

For more information, contact Provider Network Operations at (501) 210-7050 or email to providernetwork@arkbluecross.com.

BLUE & YOU

Fitness

CHALLENGE

Start your fitness journey

WALK THE TALK IN 2019

Every day, your office advises patients to be more active. The benefits are clear – improved health, happier mood, better sleep… For most people, it boils down to time and motivation. Arkansas Blue Cross and Blue Shield has a solution – the Blue & You Fitness Challenge. The Challenge is your opportunity to show patients your office's own commitment to being active and healthy.

During the contest, groups compete against similarly sized teams by performing cardiovascular and strength exercises. When you participate, we'll provide resources in the contest kit online, including:

- A setup guide to help you get started
- Motivational emails to get your group running
- Posters you can print and display as talking points for patients
- An easy-to-use website with reporting tools to manage your team

THE TIME

From March 1 – May 31, you can earn points by exercising for as little as 15 minutes

THE MOTIVATION

Be the example for patients, challenge other groups and feel great!

HOW TO PARTICIPATE

1. Create a group of at least two people, age 13+
2. Assign a group administrator, age 18+, to register your group by mid-February at **blueandyoufitnesschallenge-ark.com**
3. Have group members register by March 1 with the admin's unique group code

MOVE, LOG AND PROMOTE

From March 1-May 31, your team simply logs exercises on our website. With more than 30 eligible exercises and an "other" category, too, your team can earn points for activity they're likely already doing. Your score will be added in real-time to the leaderboard – which you can also print off and display.

Arkansas BlueCross BlueShield
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ARKANSAS DEPARTMENT OF HEALTH

ARKANSAS DEPARTMENT OF HUMAN SERVICES

A program of Arkansas Blue Cross and Blue Shield, Arkansas Department of Human Services and the Arkansas Department of Health