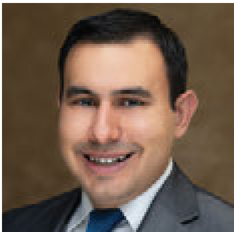
Spring 2021

Medicare Advantage NETWORK INSIDER

A resource for providers



Daniel Contreras, M.D.
Family Health Center
Mission, TX

Matt Johnson, M.D.
Family Health Center
Mission, TX

Melecia Fuentes, M.D.
Be Well Clinic
Weslaco, TX

PEER TO PEER: A Look at Practice Improvements

- Closing the care coordination loop
- Reducing patient no-shows

When patients are referred to specialists by their primary care providers, failure to "close the loop" — often the result of poor communication between practices — can reduce treatment effectiveness. What can primary care practices do to improve this care coordination issue?

Additionally, patient no-shows are common and costly, negatively impacting continuity of care and revenue. How can practices address this problem?

Network Insider recently interviewed three provider partners from Family Health Center of Mission, Texas and Be Well Clinic of Weslaco, Texas, who offered their insights on these important questions.

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3 Dedicated support for post-acute care processes

4 Tools to improve medication adherence

5 Updated practice resources and tools

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10 Wellness exam: a patient engagement opportunity

11 Transforming chronic kidney disease care

Together, all the way.®

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A MESSAGE FROM OUR CHIEF MEDICAL OFFICER

COVID-19 ... One year later

Gina M. Conflitti, M.D., MBA, FACP

In March, I celebrated my one-year anniversary with Cigna. I took on the role as the first cases of COVID-19 were reported in the U.S. Soon after, we all started to feel the real impact the virus would have on our lives. Since then, we've come a long way toward understanding the virus. And now, both treatment and vaccines offer hope for the future.

The pandemic has presented a host of challenges for us all. COVID has made a dramatic impact on patients' lives. They've had to learn to wear masks while isolating from friends and family members and giving up many of the routine activities they took for granted — all while fearing they might contract a potentially deadly disease. Physicians have persevered through one of the most significant pandemics in history, demonstrating incredible fortitude and resilience.

Together, we've worked to understand how to best meet the needs of your Medicare patients, a population shown to be at highest risk for COVID-19. With your partnership, we've worked to ensure they could continue to receive important, medically necessary health care services, as well as behavioral health support to address social isolation, anxiety and depression.

Practices nationwide experienced their own set of challenges, including dramatic decreases in patient volume and impact on practice stability, along with the stress of being on the frontlines and ensuring the safety of your own caregiving teams. You responded with flexibility, resiliency and dedication to patient wellness, from encouraging patients to get the flu vaccine in a year it's never been more important, to exploring telehealth, which has become a vital link between provider and patient. So vital, in fact, that a McKinsey COVID-19 survey found that patient use of telehealth services increased from just 11% in 2019 to an astonishing 46% in 2020.[1]

To date, more than 41,000 Cigna Medicare Advantage patients have tested positive for COVID-19. Here are some ways we've worked to remove barriers to care for this population:

- Waiving prior authorization requirements for hospitals experiencing COVID-19 capacity issues
- Extending approved prior authorization to 180 days
- Making it easier for you to treat patients virtually and expanding virtual care capacity
- Providing resources to make it easier for you to help your patients manage stress and build resiliency

We appreciate your resourcefulness, creativity and innovative spirit. Thank you for your continued partnership.

Gina M. Conflitti, M.D., MBA, FACP
Chief Medical Officer
Cigna Medicare Advantage

[1] McKinsey Consumer Survey. Telehealth: A quarter-trillion-dollar post-COVID-19 reality? May 29, 2020. Accessed February 10, 2021.

POST-ACUTE CARE PROCESSES MADE SIMPLER

To ease the transition from hospital to post-acute settings, Cigna has created a dedicated post-acute care team and streamlined the prior authorization (PA) process.

Improvement highlights

- Requests for transition to skilled nursing facility, inpatient rehabilitation and long-term acute care hospitals are now processed seven days a week for more timely transfers.
- Three-day hospital stays are not required for transfer to a skilled nursing facility. A transfer can occur from home, a physician's office, an emergency room or from observation status. PA is required.
- A dedicated team of RN care managers processes all post-acute transition requests.
- The Cigna Care Manager will notify the requesting provider verbally and in writing of the determination to expedite transfer.

What this means for you

- A more timely, efficient and collaborative PA review process
- Speedier turnaround on transition requests
- Dedicated intake team for support

Submit requests via:

- Phone: **1-800-558-3644**
- Fax: 1-866-730-1896

EXACTLY AS PRESCRIBED?

Cigna can help improve medication adherence

Medication adherence is a daunting challenge for providers and senior patients, in large part because this population tends to have multiple comorbidities and complicated drug regimens. Other barriers, such as high costs, adverse reactions, side effects and difficulties obtaining prescriptions, compound the issue.

By taking advantage of two Cigna alliances, you can improve adherence by closing gaps in care and lowering costs for your patients. Here's how:

The **Express Scripts Home Delivery Pharmacy®** is the preferred home delivery pharmacy* for many Cigna Medicare Advantage patients. This partnership makes it easy — and often less expensive — for your patients to fill maintenance prescriptions. It also provides tools to boost adherence, including refill reminders, auto-refill options, telephone support and a mobile app.

Accredo specialty pharmacy identifies prescriptions with expiring prior authorizations (PAs) early, then notifies you when it's time for renewal — before nonadherence occurs. Accredo will fax you an electronic PA (ePA) form, with sections prepopulated for easier completion. In most cases, you'll receive a real-time PA approval. Learn more at **Accredo.com/prescribers/manage_referrals**, and find the latest Accredo specialty pharmacy list at **MedicareProviders.Cigna.com** > Pharmacy Resources.

What you can do to improve adherence

- Write 90-day prescriptions and recommend home delivery if appropriate
- Talk to patients about:
  - Any barriers they're experiencing
  - Connecting their medication regimen with a daily activity
  - Using a reminder app

Cigna's Part D Partnership Guide (see sidebar below) includes more recommendations for improving adherence.

MAKING OTC ACCESS EASIER

Cigna gives Medicare Advantage patients a quarterly over-the-counter (OTC) allowance for items like cold medicine, vitamins, bandages and toothbrushes, shipped free of charge. A catalog of OTC items is available at **CignaMedicare.com/otc** or by calling **1-866-851-1579 (TTY 711)**.

*Other pharmacies are available in our network. Preferred pharmacies are not available in all plans. For a complete list, visit **CignaMedicare.com**. Express Scripts Pharmacy may also contract with other Medicare Advantage Plans. Express Scripts Pharmacy is a trademark of Express Scripts Strategic Development, Inc.

PHARMACY SUPPORT TOOLS

Better medication adherence has lasting effects on health outcomes and is reflected in improved CMS Star ratings. Our updated **2021 Part D Partnership Guide** helps you learn:

- How medication use impacts Star ratings
- How to close care gaps and boost medication adherence
- Statin use guidance for patients with diabetes

Find at: **MedicareProviders.Cigna.com/az-region** > Pharmacy > Medication Adherence.

2021 Drug Formulary Quick Reference Guide

- Most current list of commonly prescribed drugs by plan

Find at: **MedicareProviders.Cigna.com/az-region** > Pharmacy > 2021 Cigna Medicare Advantage Drug Formulary.

UPDATED PRACTICE RESOURCES AND TOOLS

Clinical decision making moves to MCG Care Guidelines

Medical necessity determinations moved from InterQual to Milliman Care Guidelines (MCG), effective January 1. This change has no impact on referrals and only affects prior authorization requests submitted on or after this date.

MCG is one part of the overall decision-making hierarchy, which includes National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs) and other scientific/peer-reviewed standards.

What this means to you

- Care guidelines better align with national industry standards
- More consistency across level of care determinations, supporting continuity of care and better patient outcomes

Note: Some contracts require InterQual. Contact your Network Operations Representative with questions.

Your 2021 ICD-10 toolkit is here!

Three tools make coding and documentation easier

The *ICD-10 Provider Partnership Guide* is your searchable, digital guide to all things coding and documentation. Want something more compact? The *ICD-10-CM Quick Reference Guide* (desktop size) and the *ICD-10-CM Pocket Guide* (pocket size) offer access on the go. Find the Partnership Guide and QRG at **MedicareProviders.Cigna.com/az-region** > Coding and Documentation, or request printed copies from your Network Operations Representative or Provider Education Specialist.

2021 Provider Manual is available

Go to **MedicareProviders.Cigna.com/az-region** > Provider Manual. Updates include:

- Prior authorization code changes
- Revised referral guidelines
- Updated appeals contact information
- Expanded service areas and new markets

Download our **Medicare Advantage Provider Quick Reference Guide** for the resources you need to do business with Cigna: **MedicareProviders.Cigna.com/az-region** > Quick Reference Guide.

PEER TO PEER

CLOSING THE CARE COORDINATION LOOP

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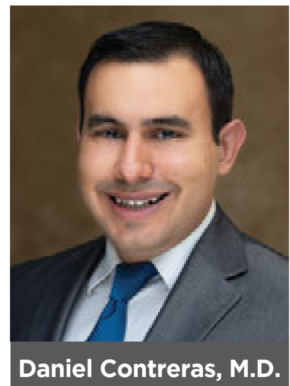
Daniel Contreras, M.D.

Matt Johnson, M.D.

THE CHALLENGE

- Only 20% of referrals closed timely
- Potential for medication errors, duplication of tests, misdiagnoses

Family Health Center of Mission (FHCM) staff suspected they had room to improve their care coordination process. A closer inspection of office data confirmed it: Only about 20% of referrals they made were closed in a timely manner with a written report from the specialist. And, as all primary care providers know, communication with specialists is critical.

"We highly appreciate knowing as much as possible about the issues affecting our patients," says Daniel Contreras, M.D. "Sometimes they may not get all the answers they're looking for at a specialty clinic. Specialist notes give us details we can use to help patients better understand their own health."

But often, specialist notes don't end up in the patient's chart for a number of reasons: Patients might not show for their appointment; they may reschedule; or if they do keep the appointment, consult notes must pass through many hands to get into the chart before the patient returns for a follow-up with the PCP.

To address the issue — and ultimately close the loop with more patients — the practice needed to understand where communication breakdowns were occurring. Working with Office Manager Yahaira Castro, the doctors reached out to FHCM staff as well as the specialists they frequently refer to.

"We really wanted to drill down and find out from the second we hit 'send' from our electronic health record to [the specialist's] office, what happens next?" says Matt Johnson, M.D. "Who looks at it?" What's involved for the specialist to complete the report and get it back to us? What if the patient doesn't show up?"

Understanding the challenges specialty practices face on the receiving end of a referral led the FHCM team to take the initiative and overhaul their entire referral process.

> ***"This process equipped us with the knowledge of how to step back, ask good questions and drill down to find specific, meaningful solutions."***
>
> — Matt Johnson, M.D.

THE SOLUTION

- Overhaul referral process
- Realign staff
- Boost communication and collaboration with specialists

Each of FHCM's four doctors worked within their own "pod," and each pod had its own way of handling referrals. The first, and most obvious, solution was to establish a practice-wide process for referrals. They created a referral coordinator position and reassigned an existing team member to it to initiate, track and close the loop on all referrals. This freed medical assistants from dealing with referral paperwork and allowed them to focus on contacting specialists if patient reports/notes weren't received within a certain timeframe.

Next, the practice turned to boosting collaboration with their go-to specialists. Drs. Johnson and Contreras developed a Care Compact agreement, a letter they sent to a select group of specialty clinics that welcomed them to FHCM's medical neighborhood and encouraged them to work collaboratively to close referral gaps.

"If we send a patient to a specialist's office, we want to know if they didn't show up so we can help coordinate care for that patient, whether it's a transportation problem or something else," says Dr. Contreras. "There are so many things that can get in the way of a patient showing up to the specialty clinic."

> ***Within two months of implementing the new process, the practice averaged a 50% return on specialist notes.***

Dr. Contreras learned from one cardiologist the challenges of handling a large number of referrals, and they reached an agreement designed to improve the process for both practices.

"We concluded it would be a one-on-one dialogue," says Dr. Contreras. "Any patient we send, the specialist would send a note back to our office. He can do that with just a few clicks of his electronic medical record."

The doctors are pleased with the progress they've made. In two months after implementing the new process, they were already averaging a 50% return on specialist notes.

"This will improve patient care because there's a higher level of communication with the specialist," says Dr. Johnson. "A lot of times, specialists will have a more specific diagnosis, perhaps one with higher risk scores."

This level of detail allows FHCM to be more active with the diagnosis, which Dr. Johnson says can help improve risk scores.

Dr. Contreras agrees, reiterating that closing the referral loop gives patients not only a more complete picture of their health, but also reduces potential for medication errors and misdiagnoses, and helps avoid duplication of tests.

"I think that helps decrease the burden on the patient and overall cost for the patient," he says.

LESSONS LEARNED

Both doctors believe FHCM's referral process improvements have paid off in time and effort saved.

Dr. Contreras offers this advice to other practices looking to improve: "Find time to devote to the betterment of your clinic."

Dr. Johnson agrees: "This process equipped us with the knowledge of how to step back, ask good questions and drill down to find specific, meaningful solutions."

Successful care coordination requires clear, timely collaboration between primary care and specialists. Ensuring all providers share important clinical information and are fully apprised of a patient's treatment plan will result in better patient outcomes and, ultimately, time and cost savings. Strong care coordination is also a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey measure that providers have the most ability to impact.

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PEER TO PEER

REDUCING PATIENT NO-SHOWS

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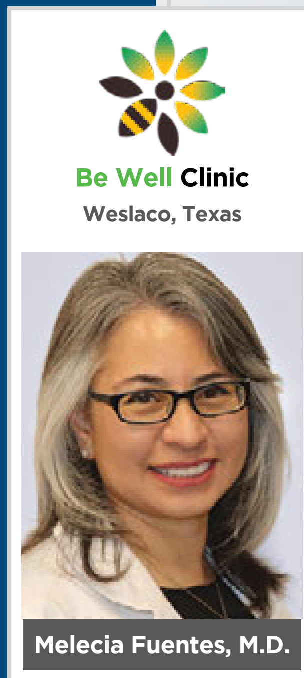


THE CHALLENGE

- **Poor continuity of care**
- **Revenue loss**
- **Unpredictable schedule**

Patient no-shows are a common and costly problem. In addition to negatively impacting continuity of care, they can also result in revenue loss. After a thorough records audit, Melecia Fuentes, M.D., and her team realized their no-show policy was ineffective. The clinic was charging a fee after two missed visits, but the volume of patients only missing one was significant. And of those patients charged a fee, most never paid it and were subsequently discharged from the practice.

"We want to still be able to care for them, but do so efficiently," says Dr. Fuentes.

So her team convened to brainstorm solutions.

THE SOLUTION

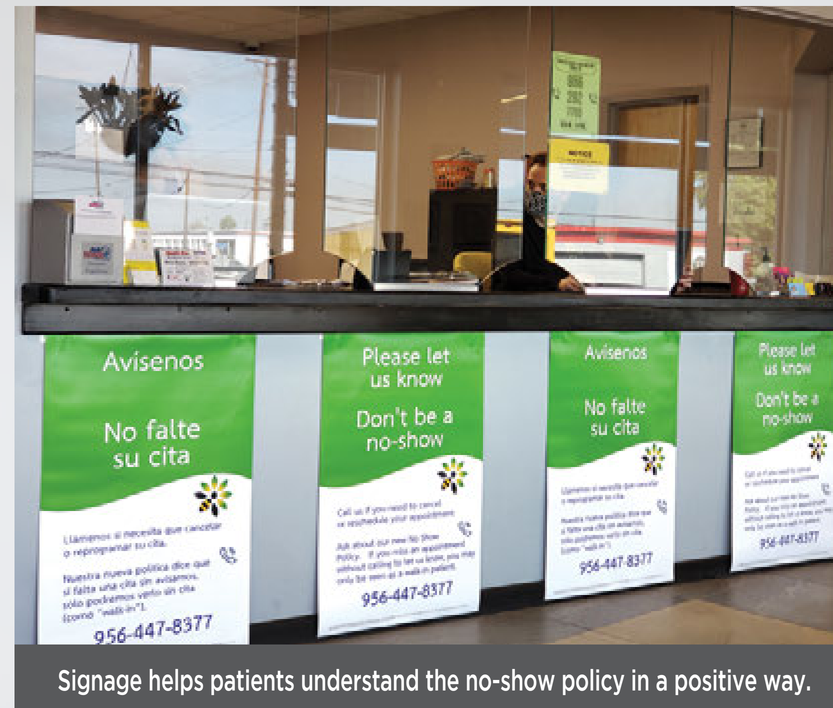
- **Implement patient-centered no-show policy**
- **Script positive messaging for staff**
- **Ease rescheduling**

For Dr. Fuentes, it was vital that any new policy be presented in a way that didn't make patients feel unwelcome and ensured equal access for all. So, her office changed the way it handles missed appointments and no-show fees, replacing the current approach with this:

- After one missed appointment, a patient can no longer schedule an appointment but must visit the clinic as a walk-in. Because of the value of routine preventive care, however, appointments for annual wellness exams are not subject to this policy.
- If the patient wishes to schedule appointments again for services other than annual wellness exams, they must first pay a $40 no-show fee.*

Staff explained the new policy to patients using scripted talking points, which were carefully crafted to present the message in a positive way. They reinforced the policy with an awareness campaign using buttons that staff wore and posters at the clinic entrance and in the lobby. The practice also made it easy for patients to reschedule, allowing them to leave a voicemail or send a message through the patient portal, as late as one hour before their appointment.

The approach netted dramatic results. In just two months, the clinic's no-show rate dropped from 9.2% to 5.5%. Dr. Fuentes expects it to drop even more as patients became more accustomed to the policy. So far, it's been well received by patients, and the practice is enjoying a more predictable schedule.



Signage helps patients understand the no-show policy in a positive way.

LESSONS LEARNED

Dr. Fuentes attributes their success to keeping communications with patients positive. Clinic staff even practice by role playing, shifting the tone from punitive to positive, to hone their message for the best results.

"Instead of saying, 'You were a no-show; we have to reschedule you,' we say, 'I'm sorry you missed your appointment, but let me see what I can do to get you in,' thus focusing on how they can help the patient even if they missed their appointment," Dr. Fuentes says. "We communicate what we can or will do for them, not what we can't or won't do."

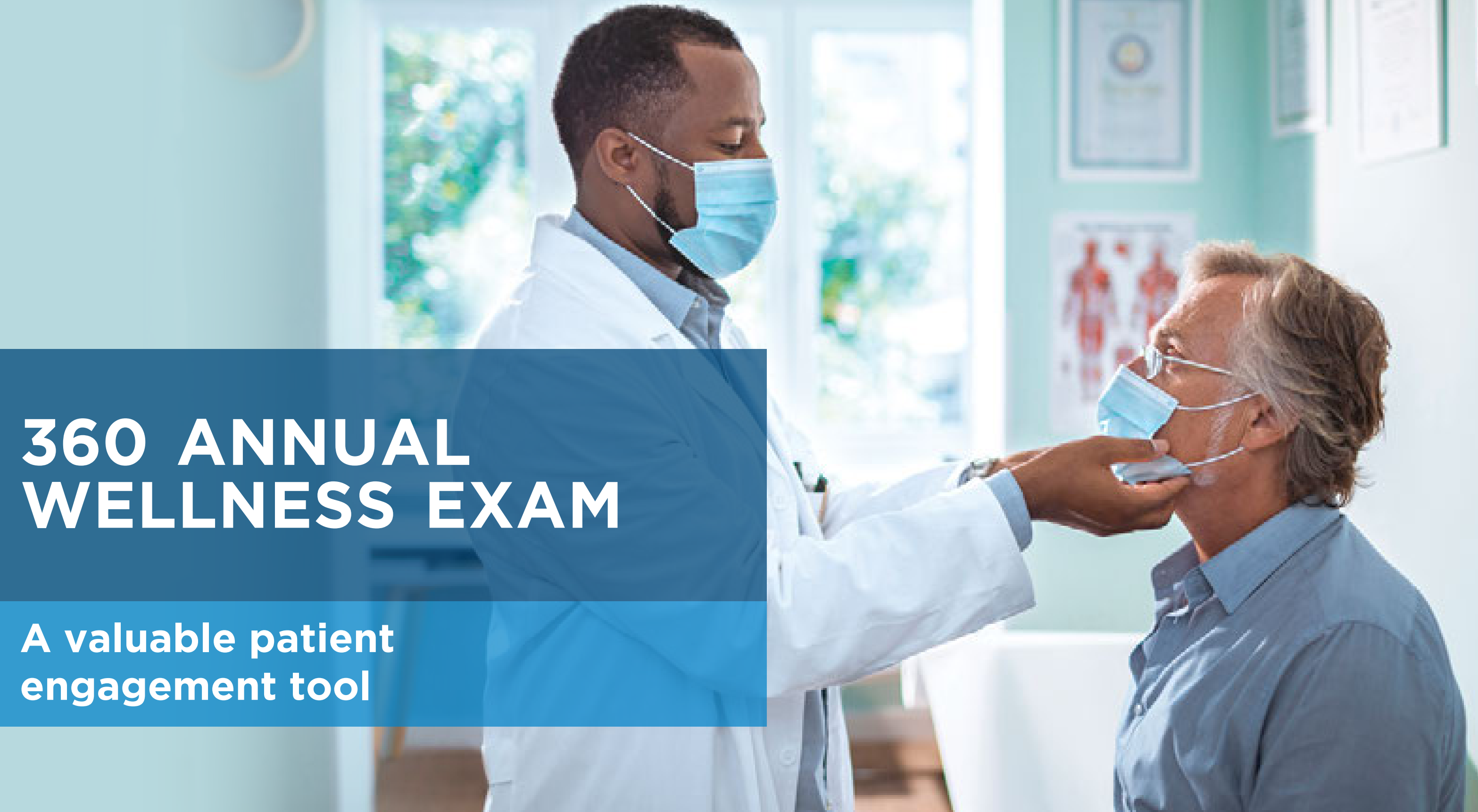
> ***In just two months, the clinic's no-show rate dropped from 9.2% to 5.5%.***

* CMS guidelines allow providers to charge for missed appointments, provided they don't discriminate against Medicare beneficiaries (i.e., they also charge non-Medicare patients, and the charges are the same for all patients). See Medicare Claims Processing Manual, Chapter 1, Section 30.3.13.

COVID-19 RESOURCES FOR PROVIDERS

Visit our Coronavirus (COVID-19) Resource Center at **MedicareProviders.Cigna.com** for:

- Billing guidelines
- Telehealth CPT and diagnosis codes
- FAQs
- Resources to support your mental health (live-guided relaxation via telephone, wellness podcasts)
- Virtual Care Reimbursement Policy information
- Links to CMS COVID-19 vaccine resources



360 ANNUAL WELLNESS EXAM

A valuable patient engagement tool

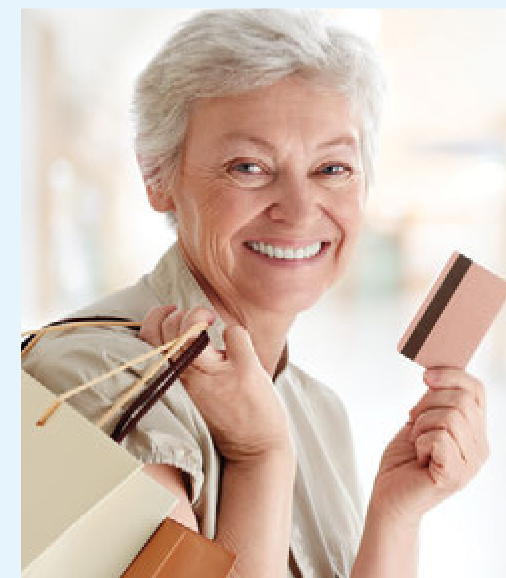
The Cigna 360 Annual Wellness Exam is an ideal tool for gaining a complete picture of your Medicare Advantage patients' health. It can then serve as a roadmap to assist you in the care you provide — care that's ultimately more holistic, patient-centric and outcomes based.

Cigna supports two options for completing/submitting 360 Exams:

- A customized 360 Exam template embedded in your EMR
- 360 Annual Wellness Exam paper form

Cigna is offering continued provider financial incentives for completing 360 Exams in 2021. If you haven't been notified, reach out to your Network Operations Representative.

Questions? Reach out to your Provider Education Specialist, or email **CCQI@Cigna.com**.



360 INCENTIVES FOR PATIENTS IN 2021

Starting in 2021, your Cigna Medicare Advantage patients can earn up to a total of $50 in gift card incentives: $25 for completing their yearly 360 Exam (wellness exam), plus another $25 for completing any of these recommended screenings by December 31, 2021:

- HbA1c
- Diabetic retinal exam
- Mammogram
- Colorectal cancer screening

TRANSFORMING KIDNEY CARE

New partnership extends support for patients with advanced disease

The Centers for Disease Control and Prevention (CDC) estimates that 15% of U.S. adults have chronic kidney disease (CKD). This adds up to about 30 million people — more than one in seven patients — that physicians see every day.

On January 1, the 21st Century Cures Act began permitting certain previously ineligible patients with end stage renal disease (ESRD) to join Medicare Advantage plans. This change is likely to increase your volume of patients with advanced kidney disease.

Notably, African Americans, Hispanics and American Indians are at higher risk for CKD, possibly because of genetic factors and/or lack of access to primary care. Through a partnership with Monogram Health, Cigna is ready to help you serve this high-risk, high-cost and vulnerable population.

How it works

Designed to be an extension of the patient's nephrologist, Monogram Health nurses, licensed social workers and care coordinators provide personalized, in-home care management and care coordination for your Cigna Medicare Advantage patients with advanced stage CKD and ESRD.

Eligible patients are invited to join the program in one of two ways:

- Monogram Health contacts patients identified by Cigna as candidates based on a CKD or ESRD diagnosis. If one of your patients enrolls, you'll receive a notification letter from Monogram Health.
- You can submit a request for an eligibility assessment for your patient.

Once enrolled, the patient and their caregivers receive personalized in-home education, including coaching on dietary/nutrition needs and medication adherence. The Monogram Health care team monitors the patient's weight and blood pressure, coordinates appointments and shares information between providers, helps identify community-based resources, and more. Patients and their providers can call the care team at any time.

Learn more

For information about Monogram Health's proactive approach to addressing whole-person health needs in your patients with advanced kidney disease, visit monogramhealth.com, call **615-619-1070** or email **info@monogramhealthcare.com**.

For information on dedicated ICD-10 coding and documentation training related to CKD, contact your Provider Education Specialist at **ProviderEducation@Cigna.com**.

We've created a Quick Reference Guide for all our clinical patient support programs, which you can use to find resources to support your patient treatment plans and request patient evaluations. Find it at **MedicareProviders.Cigna.com/az-region** > Health Care Provider Information.

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> – Gina M. Conflitti, M.D., MBA, FACP
> Chief Medical Officer
> Cigna Medicare Advantage

Medicare Advantage

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500 Great Circle Road
Nashville, TN 37228