Clear Spring Health

PROVIDER NEWSLETTER

WINTER 2023

MOC • eCare Home Monitoring Program • HEDIS® Reminder

The Centers for Medicare and Medicaid Services (CMS) require that health plans that offer a Model of Care (MOC) provide their network physicians with information and training. Education and training apply to both Dual Eligible Special Needs Plan (D-SNP) members, who are eligible for Medicare and Medicaid, and Chronic Condition Special Needs members (C-SNP) who have one or more qualifying conditions.

The MOC provides the basic framework under which the SNP will meet the needs of its members. The MOC is a vital quality improvement tool and integral component for ensuring that the unique needs of each member are identified and addressed through the health plan's care management practices. The MOC provides the foundation for promoting SNP quality, care management, and care coordination processes.[1]

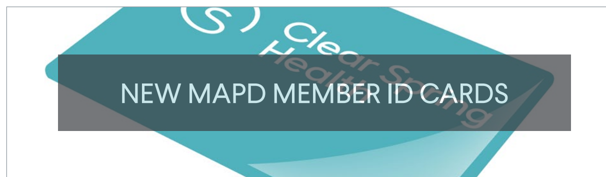
We ask that you partner with us to ensure we are giving the highest quality of care possible to our SNP members by performing the following activities:

- **Complete the annual MOC training** posted in our website found under PROVIDERS › PROVIDER OVERVIEW › MOC TRAINING
- Upon completion of the training, please complete the Model of Care (MOC) Attestation form located under PROVIDERS › PROVIDER OVERVIEW › MOC ATTESTATION and send back to our Provider Relations department.
- Actively communicate with our Care Management department if there are any questions with regard to a SNP member's care plan.
- Collaborate with the health plan, care managers, member, and caregivers to update member's care plan.
- Accept invitations to attend member's Interdisciplinary Care Team (ICT) meeting whenever possible.
- Maintain copies of the Member's Care Plan, Transition of Care Notifications (admission/discharge letters) in the member's medical record when received.

For a complete copy of the Model of Care submitted and approved by the National Committee for Quality Assurance, you may reach out to:

Clear Spring Health's Quality Improvement department: 844-895-9047.

1. Model of Care (MOC): https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNP-MOC

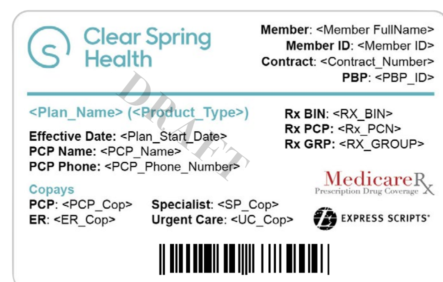


Clear Spring Health updated the ID card to remove the old tri-logo and provide additional contact information in the back of the id card.

Please note that the ID cards will have the member's original effective date. For example, if they joined Clear Spring on 01/01/2019 this will be the effective date on the new ID card.

Old Card

New Member ID Card



The eCare Home Monitoring Program is designed to monitor members who are diagnosed with Hypertension. Eligible Clear Spring Health members receive special equipment allowing them to take their vital signs in the comfort of their home. The equipment transmits the results to an eCare Nurse Coordinator, who reviews the blood pressure readings as they are received. If the readings are not within normal range, the eCare Nurse contacts the member and the member's primary care physician (PCP) to discuss the results and next steps.

The GOALS

Improve member outcomes

- Member accessing their own data have a better understanding of their disease
- Empower members to better manage their health

Improve member experience

Enhance accessibility – Factors such as distance, lack of vehicles, transportation cost and inadequate infrastructure can hinder a member from accessing care. Members living in rural areas face a barrier to obtaining frequency of care. Remote monitoring is an effective way to reach these members and assess if members are addressing their chronic needs.

Provide convenient care with real-time data
Remote monitoring helps reduce inaccurate data due to gaps in member health awareness.

Improve patient-provider communication – Remote monitoring often increases the frequency of communication between members and their care team and consequently helps improve overall communication.

Increase patient support – Remote monitoring provides members with all the support they need not only by monitoring their blood pressure but also by having access to a qualified nursing staff.

Reduce costs by:

- Preventing or reducing all causes of 30-day hospital readmission among High-Risk members with Hypertension
- Allowing early detection and decreasing ER utilization due to an exacerbation of medical condition
- Decreasing the number of unnecessary outpatient visits

WHO IS ELIGIBLE?

Members eligible to participate in the eCare Home Monitoring Program must have the following criteria:

- Diagnosis of Hypertension

HOW TO REFER YOUR MEMBER?

eCare Home Monitoring Program information can be found in the Clear Spring Health website. Download the Provider Referral Form from our website, complete the form and email or fax the form back to the Quality Improvement department.

The eCare nurse team takes care of the rest!

Where is the Referral Form located within the Clear Spring website?

https://clearspringhealthcare.com/ecare/

HOW DOES IT WORK?

1. Upon member enrollment to the eCare Program, the nursing staff performs the following:
   - Reaches out to member to obtain member consent and verify demographic information.
   - Ships out the equipment to the member's home.
   - Conducts additional member outreach once equipment is delivered.

2. Members are monitored on a continuous basis through real-time software and based on this, the eCare nurses employ clinical protocols applicable to member's specific healthcare needs.

   Daily Home Monitoring is performed: Monday – Friday 8:00 am to 6:00 pm EST. Nursing personnel is available for immediate member attention. After hours, weekends and holidays, nursing assistance is available through the nursing hotline (Team Health).

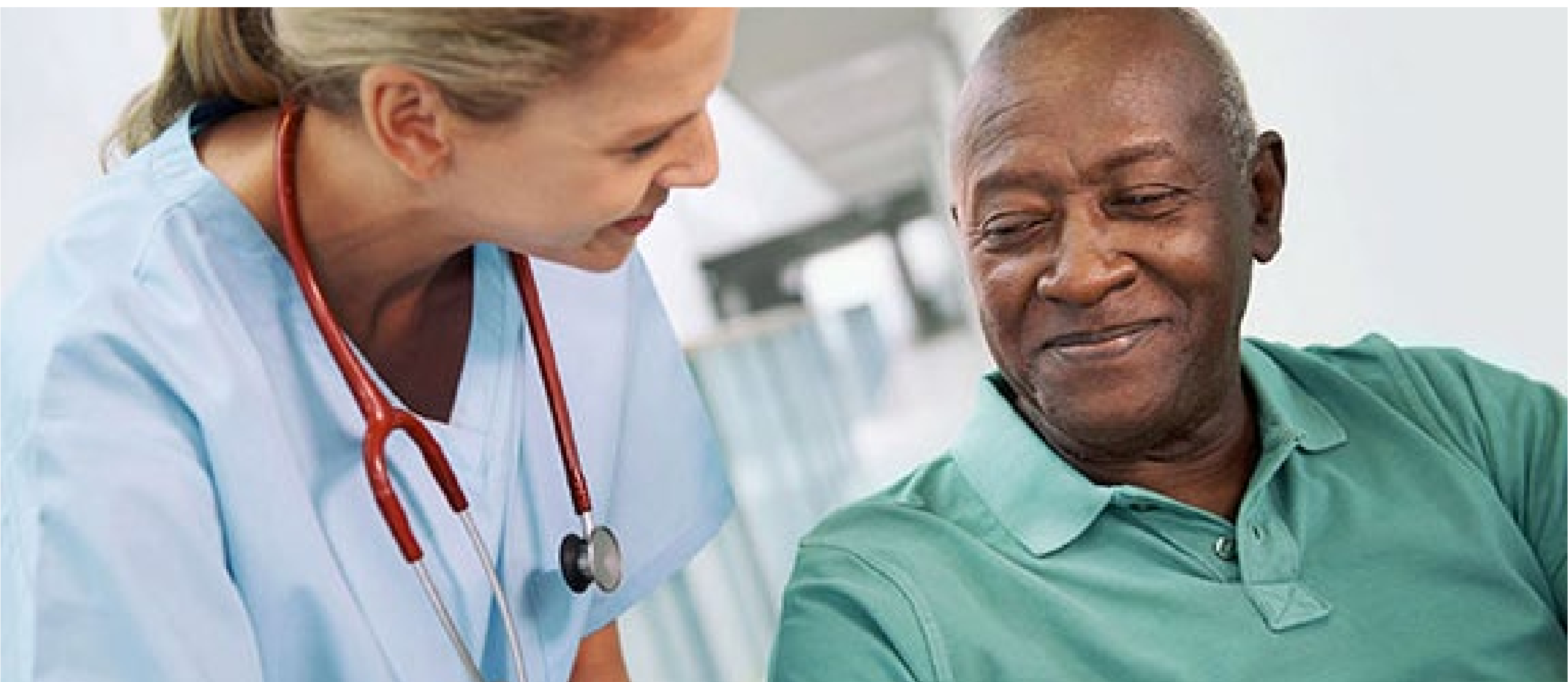
3. A Care Plan is developed by the eCare nurse and member together engaging the member in joint decision-making. The member, provider and/or caregiver are encouraged to review the Care Plan and update goals and/or interventions that would assist the member in achieving improved health outcomes.

   The eCare nurse communicates regularly with member and helps customize the care plan with member. The initial Care Plan is shared with the PCP and every time there is a change in member's status (i.e. member hospitalization, change in diagnosis, etc.).

   The following communications are shared with member's primary care provider via fax and/or email:
   - Initial Intake Survey
   - Member's individualized Care Plan
   - Out of range blood pressure alert readings (immediately upon identification)
   - Monthly blood pressure reading reports to track and trend member's blood pressure readings over time

We encourage all our participating providers to refer members to the eCare Home Monitoring Program!

For questions, please contact the Quality Improvement department at: 844-895-9047.



IMPORTANT

Advances Directives are no longer part of HEDIS medical record review.

Have you started discussing Advance Directives with your patients? We recommend this discussion to happen at least once a year, especially for members 66 years of age and older or members with frailty or receiving palliative care. This discussion should be documented, even if the patient did not choose to complete any legal forms such as a Living Will or Healthcare Power of Attorney. It can be done as part of the patient's Medicare Wellness Visit. To get credit for HEDIS®, submit a claim for this service using the following codes as applicable:

Advance Care Planning		
CPT®/CPT II	**HCPCS**	**ICD-10**
99483, 99497, 1123F, 1124F, 1157F, 1158F	S0257	Z66

HEDIS medical record abstraction for Measurement Year 2022 has begun! Please be aware that we may request medical records from your office for patients you have seen.
These records can be faxed to us to 1-800-903-5827
or emailed to our secure email: qualityimprovement@clearspringhealthcare.com

Questions? Reach out to the **Quality Improvement department at 1-844-895-9047**.

Below is a summary of the measures that you may be requested to provide and what the request means.

MEASURE	DOCUMENTATION NEEDED FROM THE TREATING PROVIDER
CBP Controlling High Blood Pressure	Documentation needed from the treating provider: • Problem List/Progress Notes confirming the diagnosis of Hypertension. • Office visits /encounters/vital sign flow sheets documenting the patient's blood pressure (BP) in 2022. • If applicable, any evidence that the member was: - Diagnosed with end-stage renal disease (ESRD) or received a kidney transplant, or - Pregnant in 2021 or 2022, or - In hospice or using hospice services any time during 2022 • BP reading from a remote monitoring device. Readings must be reviewed by the provider. • Patient-reported BP (provider must ensure that reading was taken with a digital device).

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MEASURE	DOCUMENTATION NEEDED FROM THE TREATING PROVIDER
CDC Comprehensive Diabetes Care	**Blood Pressure for Patients with Diabetes (BPD)** Documentation needed from the treating provider: • 2022 office visits/encounters, with vital sign sheet documenting most recent BP reading. • BP reading from a remote monitoring device, (digitally stored & transmitted) reviewed by provider. • Problem List/documentation within Progress Notes indicating any of the following: - Polycystic Ovarian Syndrome - Gestational Diabetes - Steroid Induced Diabetes - Patient in hospice or received hospice services during 2022 - Patient receiving palliative care **CDC Hemoglobin A1C Control for Patients with Diabetes (HBD)** Documentation from the treating provider: • Documentation of HgA1c, glycohemoglobin or glycated hemoglobin: date test was performed and result in 2022. • Documentation indicating patient is in hospice or using hospice services any time during 2022, if applicable. **CDC Retinal Eye Exam for Patients with Diabetes (EED)** Documentation from the treating provider: • Progress notes indicating a retinal eye exam was completed with results and the name of the eye care provider (ophthalmologist or optometrist) during 2021 and 2022. • Consultation note/letter from an eye care professional indicating that an ophthalmic or diabetic eye exam was completed, must include the date and the results of the exam. • A chart or photograph with the date when fundus photography was done, evidence that an eye care professional (ophthalmologist or optometrist) reviewed the results or evidence that results were read by a qualified reading center or a system that provides an artificial intelligence (AI) interpretation. • Problem List/documentation within Progress Notes indicating patient has or has received any of the following services or diagnoses: - Bilateral enucleation - In hospice or received hospice services during 2022 - Palliative care - Polycystic Ovarian Syndrome - Gestational Diabetes - Steroid Induced Diabetes
COA Care for Older Adults	2022 Office visits/encounter/demographic information/flow sheet in which documentation of the following is found: • **Medication List & Medication Review** done during measurement year (2022) by a prescribing practitioner or clinical pharmacist.

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MEASURE	DOCUMENTATION NEEDED FROM THE TREATING PROVIDER
COA Care for Older Adults *continued*	• Any of the below **functional status assessment** during the current measurement year (2022): - SF-36®, Assessment of Living Skills and Resources (ALSAR), Barthel ADL Index Physical Self-Maintenance (ADLS) Scale, Bayer ADL (B-ADL) Scale, Barthel Index, Edmonton Frail Scale, Extended ADL (EADL) Scale, Groningen Frailty Index, Independent Living Scale (ILS), Katz Index of Independence in ADL, Kenny Self-Care Evaluation, Klein-Bell ADL Scale, Kohlman Evaluation of Living Skills (KELS), Lawton & Brody's IADL scales, Patient Reported Outcome Measurement Information System (PROMIS) Global or Physical Function Scales • **Pain assessment** during the current the measurement year 2022 • Notation that **Activities of Daily Living (ADL) were assessed** or that at least five of the following were assessed: bathing, dressing, eating, transferring (e.g., getting in and out of chairs), using toilet, walking. • Notation that **Instrumental Activities of Daily Living (IADL) were assessed** or at least four of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, cooking or meal preparation, housework, home repair, laundry, taking medications, handling finances. • Documentation indicating patient is in hospice or using hospice services any time during 2022, if applicable.
COL Colorectal Cancer Screening	Documentation within the medical record of the following: • Diagnosis or history of Colorectal Cancer or a Total Colectomy. • Documentation of one of the following screenings and the date the screening was performed: - Colonoscopy between 2012 and 2022 - Fit-DNA (Cologuard®) between 2019 and 2022 - Fecal occult blood test (FOBT) in 2022 - Flex sigmoidoscopy between 2018 and 2022 - Computerized tomography (CT) colonography between 2018 and 2022 • Documentation indicating patient is in hospice or using hospice services any time during 2022, if applicable. • Any documentation from a gastrointestinal consult.
TRC Transitions of Care	Documentation within the medical record of the following: • **Receipt of notification of the inpatient admission** on the day of admission or the following day, with a date and time stamp. This can be: - Any communication between inpatient providers or the emergency room department and the primary care providers (faxes, emails, phone calls). - A Health Plan notification letter informing of member's admission. • **Receipt of the discharge information** on the day of discharge or the following day or Discharge summary/summary of care record. This can be: - A Health Plan letter providing discharge summary of the member's admission. - Any communication between inpatient providers or the emergency room department and the primary care providers (faxes, emails, phone calls).

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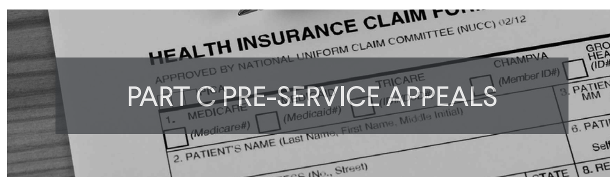
MEASURE	DOCUMENTATION NEEDED FROM THE TREATING PROVIDER
TRC Transitions of Care *continued*	• **Patient engagement** within 30 days of discharge. This may be: - Any outpatient visits after the member's discharge. It may include office visits, home visits, & telehealth visits. • **Medication reconciliation post-discharge**. This may be: - Documentation within the member's medical record that the discharge medications were reconciled with the most recent medication list in the outpatient record and the date when it was performed. • Documentation indicating patient is in hospice or using hospice services any time during 2022, if applicable.



If a prior authorization request is fully or partially denied the member or provider can file an appeal. You can find the Part C Pre-Service appeal form on our website at: https://clearspringhealthcare.com/appeals-grievances/

Please include the following: A copy of the initial request, a copy of the denial, and clinical documentation supporting the appeal request. Please attach all documents to avoid delays in processing your request.

Send completed form by fax, mail or email

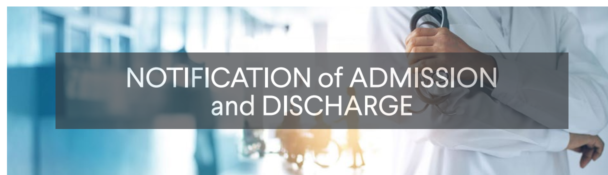
Fax: 1-866-235-5181

Email: A&G@clearspringhealthcare.com

Mail: Clear Spring Health
3601 SW 160th Avenue, Suite 450
Miramar, Florida 33027

The processing time frames are as follows

Expedited Part C Appeals	72 hours
Standard Pre-Service Part C Appeals	30 calendar days
Expedited Part B Drug Appeals	72 hours
Standard Part B Drug Appeals	7 days



Poor communication can result in failed transitions, frequent admissions or inapprpriate utilization of services.

Clear Spring Health Utilization Management (UM) team works closely with facilities during our members' admissions and provides timely admission and discharge information to primary care providers.

Primary care providers on record will get notification of admission and notification of discharge letters via fax. The notification of discharge includes the discharge summary, and in its absence the notification will include the latest clinical information received by the UM department.

After a patient's discharge, Primary Care Providers are expected to do the following:

- Acknowledge notification of admission within 48 hours of admission date by signing and dating faxed notification or by entering a note in the member's medical record.
- Acknowledge notification of discharge within 48 hours of discharge date by signing and dating faxed notification or by entering a note in the member's medical record.
- Schedule a follow up visit with patient within 30 days of discharge
- Conduct medication reconciliation during the follow up visit after discharge.

Clear Spring Health supports coordination of care for our members and our involvement serves as an extension of your office during and beyond your patient's discharge.

You can reach the health plan Case Management department at 1-866-938-3720.

Clear Spring Health has a contract with Medicare to offer HMO, PPO and PDP plans. Clear Spring Health has contracts with the Georgia and South Carolina Medicaid programs. Enrollment in these plans is dependent upon annual contract renewal with the federal government.
2023 Clear Spring Health, 250 S. Northwest Highway, Suite 302, Park Ridge, IL 60068

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