Banner University Health Plans

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www.BannerUHP.com

July 2020 Update

Telehealth Update

From Seth M. Dubry, Associate Chief Medical Officer, Government Programs

The COVID crisis has created a fundamental shift in how we deliver health care. We are no longer wed to the notion that all visits require someone to come to the office and meet with a provider face-to-face. The ability to engage members where they are, and how they prefer to be engaged, will move medicine to the next level. Out of necessity, many providers have moved to telehealth platforms to deliver care. While we know telehealth visits will never replace those visits that require a person to be physically present, they do serve a useful and growing purpose. Not only can patients be seen in the comfort of their own home, but providers can see where, and how a member lives and tailor or adjust care based on those observations. In addition, concerned family members can "tie in" to the visits, allowing engagements that would not have been possible previously, either due to time or distance. Telehealth cannot, and should not, replace necessary in-person visits. However, it is another piece in solving the puzzle of providing the right care, at the right time. With Medicare, AHCCCS and private payers expanding telehealth support through the COVID crisis (and looking at doing so long-term), we have a unique opportunity to show the value in this technology. This is a scary and difficult time for all of us. Thank you for your hard work, partnership and dedication to our patients.

If you need additional information or guidance, please go to the following sites:
For up-to-date AHCCCS information:
https://azahcccs.gov/AHCCCS/AboutUs/covid19FAQ.html#telehealth
For up-to-date Medicare information: https://www.cms.gov/outreach-education/partner-resources/coronavirus-covid-19-partner-toolkit

Did You Know – Providers can be reimbursed for COVID-19 Testing and Treatment of Uninsured Arizonans?

From AHCCCS website

The Families First Coronavirus Response Act authorized federal reimbursement for COVID-19 testing and testing related services for any uninsured individual.

In June, the US Department of Health and Human Services, Health Resources & Services Administration (HRSA) announced the COVID-19 Uninsured Program Portal (https://coviduninsuredclaim.linkhealth.com/). The COVID-19 Uninsured Program will provide reimbursement at Medicare levels to providers and facilities for coronavirus-related testing and

treatment of the uninsured. Funding for the program is provided primarily through appropriations to the Provider Relief Fund, as well as $1 billion from the Families First Coronavirus Response Act. The administration has not yet announced how much of the Provider Relief Funds will go towards the program.

To access the funds, health care providers must register to participate in the HRSA program (https://coviduninsuredclaim.linkhealth.com/get-started.html)

Once registered, those who have conducted COVID-19 testing or provided treatment to uninsured individuals on or after February 4, 2020 may request claim reimbursement through the portal beginning May 6, 2020.

Providers will be required to verify and attest that the patient does not have individual or employer-sponsored Medicare or Medicaid coverage, and that no other payer will reimburse them for COVID-19 testing and/or treatment for that patient.

Systems of Care

Mental Health Screening and Assessment Tools for Primary Care

BUHP is committed to coordination of care for members to ensure optimal integrated care to meet their needs. Some members may have complex behavioral health (BH) and physical health conditions that require integrated treatment approaches and interventions to improve the member's health. Primary Care Providers (PCPs) are required to screen all members for depression, drug and alcohol misuse, anxiety and suicide risk at least annually or whenever symptoms are present. Using age appropriate and standardized evidence-based tools to conduct the assessment is a recommended best practice. The intent of the screening tools for PCPs is to help identify the presence of BH conditions and determine if the member's needs require specialized services beyond the PCP's scope.

You can find a comprehensive list of PCP Screening and Assessment Tools for BH at: https://www.banneruhp.com/materials-and-services/behavioral-health.

If the member may benefit, PCPs can complete the PCP Referral to BH Provider located at: https://www.banneruhp.com/materials-and-services/behavioral-health.

The benefit of completing the PCP Referral to BH Provider is that a BUHP Care Manager will be assigned to the member for additional support as needed. A referral from a PCP is not required if the member would prefer to contact a BH Provider directly or to call BUHP Customer Care at (800) 582-8686.

Your role in helping patients quit smoking

From ASHLine.org

Recent research shows that up to 70% of smokers think about quitting each year. In addition, advice to quit from a health professional is cited by tobacco users as the number one motivator to quit. The Arizona Smokers' Helpline (ASHLine) can help you become more comfortable talking to your patients about quitting tobacco use. Best of all, our services are free to all providers. ASHLIne outreach team can help you:

- Develop tobacco screening and intervention policies
- Get registered to make patient referrals
- Explore referral reporting options available to you
- Learn how to bill for intervention services

Call 1-800-55-66-222 to get started or visit www.ashline.org.

Children's Systems of Care
Adopted Children: Behavioral Health Services

In order to meet the behavioral health needs of adopted children, contracted BH providers are required to provide timely services to them. This includes but is not limited to:

- Initial assessment within 7 calendar days after referral or request for service
- Initial appointment within timeframes indicated by clinical need, but no later than 21 calendar days after the initial assessment
- Subsequent BH services within the timeframes according to the needs of the person, but no longer than 21 calendar days from the identification of need

If an adopted child does not receive medically necessary BH services within the 7 and/or 21 calendar day timeframes, the adoptive parent may contact **BUHP Customer Care** at (800) 582-8686 and **AHCCCS Clinical Resolution Unit** at (800) 867-5808 or DCS@azahcccs.gov.

Additional Links
BUHP Provider Manual: https://www.banneruhp.com/materials-and-services/provider-manuals-and-directories
AHCCCS Foster and Adopted Children:
https://www.azahcccs.gov/Members/AlreadyCovered/MemberResources/Foster/

Make Every Office Visit a Well-Child/EPSDT Visit

Banner - University Family Care (BUFC) does **not** limit the number of medically necessary billed Well Child/EPSDT Visits.

Billing of a "SICK VISIT" (CPT Codes 99201-99215) at the same time as a Well Child/EPSDT Visit is a separately billed service if:

- An abnormality is encountered, or a preexisting problem is addressed in the process of performing an EPSDT service and the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service
- The "SICK VISIT" is documented on a separate note
- History, exam, and medical decision-making components of the separate "SICK VISIT" already performed during a Well Child/EPSDT Visit are not to be considered when determining the level of additional service (CPT Code 99201-99215)
- The status (not history) of the abnormality or preexisting condition is the basis of determining medical necessity
- Modifier 25 must be added to the Office/Outpatient code to indicate that a significant, separately identifiable evaluation and management service was provided by the same physician on the same day as the preventive service

Generally, members will not want to come back for a Well Visit/EPSDT. Being able to include with the sick visit will capture this valuable exam.

Perinatal Psychiatric Consult Line

Diagnosing a perinatal mental health disorder is not always straightforward, and medication is not always immediately effective.

The Postpartum Support International (PSI) perinatal psychiatric consultation line is a service provided at no cost to medical providers. The consultation line is available for medical professionals who have questions about the mental health care related to pregnant and postpartum patients as well as pre-conception planning. The Perinatal Psychiatric Consult Line is staffed by reproductive psychiatrists who are members of PSI and specialists in the treatment of perinatal mental health disorders. PSI's expert perinatal psychiatrists are available to share their skills and expertise with fellow medical professionals, providing necessary guidance and reassurance on any matter, but particularly those that may be more challenging.

For more information:

- Call 800-944-4773, ext 4
- https://www.postpartum.net/professionals/perinatal-psychiatric-consult-line/

Pre-Service Authorization/Utilization Management News

Behavioral Health Training Video Now Available

On the homepage of our website, you'll find a Behavioral Health training video to assist you with some of the following topics:

- Review new requirements for providers requesting authorizations and continued stays, including clinical documentation submittals and timelines
- Understand the requirements for discharge planning and submittal of discharge information for reimbursement
- Review the new requirements for inpatient facilities to request a Retrospective Review
- Review the new AHCCCS/B – UHP criteria for admission, continued stay and discharge for Therapeutic Foster Care and Adult Behavioral Health Therapeutic Home levels of care

Thank you for attending June Trainings

Thank you for participating in our online BH PA/UM Trainings held on June 16, 18 and 24! Our BH Provider Quarterly Training winners were: Theresa Mucci Vega - Southwest Behavioral and Health Services (6/24/20), Leslie Babers - Pathways of Arizona (6/18/20) and Keah Tucker – Unhooked Recovery (6/16/20).

Updated forms available

As a reminder, on June 1, 2020, the following forms were updated on the BUHP website:

- Transfer Request
- Out of Home Application
- Out of Home Admission Notification
- Behavioral Health Prior Authorization

Provider Relations: Supporting You and Your Staff

We look forward to connecting with you! All contracted BUHP Network Providers are assigned a dedicated Provider Relations Representative to answer questions, offer training and connect you to resources and information. If you would like to contact your Provider Relations Representative, please send your contact information including your group name and Tax Identification number to: BUHPProviderNotifications@bannerhealth.com.

CAHPS Survey Flyer

Did you know that you can have an influence on your CAHPS scores? By providing excellent customer Service and being aware of the questions that your patients may be asked, you can have a positive influence on the survey scores. We've developed a flyer that demonstrates the actions you can take. A copy of the flier is included at the end of this newsletter.

Claims Update

Initial claims may not be submitted directly to our corporate office; doing so will result in claims being returned and not accepted for processing. For your convenience, the claims mailing addresses and electronic payer identification numbers have been listed below for your reference. Please note: if you use a third party billing company please ensure the correct addresses are updated in your contract.

Banner University Health Plans encourages providers to submit claims electronically. Claims may be submitted through your clearinghouse to one of our EDI partners. Please contact your Provider Relations Representative for more information.

Banner - University Family Care / AHCCCS Complete Care (BUFC / ACC)
P.O. Box 35699
Phoenix, AZ 85069-7169
Electronic ID: 09830

Banner - University Family Care / Arizona Long Term Care System (BUFC / ALTCS)
P.O. Box 37279
Phoenix, AZ 85069
Electronic ID: 66901

Banner - University Care Advantage (BUCA) (HMO SNP)
P.O. Box 38549
Phoenix, AZ 85069-7169
Electronic ID: 09830

Pharmacy

Myth: Concerns about Low LDL – Statin Quality Measures

Have you or your patients ever been hesitant to begin statin therapy due to "low" LDL? Guidelines recommend statin therapy in patients with established ASCVD and/or diabetes

mellitus, regardless of baseline LDL. Treatment targets in guidelines are based on calculated LDL, typically less than 70mg/dL or 100mg/dL but how low can you safely go?

Safety: Some literature suggests there is an association between lower LDL and higher risk of intracranial hemorrhage. This data contains several limitations, including lack of generalizability as most patients with this association are not taking lipid-lowering agents. **Overall, data suggests there is no offsetting adverse effects of low LDL in majority of patients.**

- Many trials have intentionally achieved LDL <70mg/dL; no adverse events in patients with LDL <25mg/dL and median of 21mg/dL
- No statements of unsafe LDL level at which to back off statin

Efficacy: Established cardiovascular benefits of statin therapy far outweigh risk of adverse effects. Recent cholesterol guidelines reiterate that **lowering LDL by every 1% can lead to a 1% reduction in ASCVD risk**.

- Statins have known pleotropic effects in addition to cholesterol-lowering
- No statements of assessment of baseline LDL prior to initiation of therapy if meet other criteria to fall into statin-benefit group

Clinical Application: **Initiate statin therapy in patients with established ASCVD (SPC) and/or diabetes mellitus (SUPD), regardless of baseline LDL**. In majority of patients there is minimal clinical concern for very low LDL.

- Ensure appropriate interpretation of fasting lipid panel; LDL is underestimated at low levels and calculated LDL will be falsely low if labs are drawn in an unfasted state
- Consider more conservative statin therapy only in patients with cholesterol-lowering indications also at high risk for hemorrhagic stroke (age > 65 years, uncontrolled hypertension, high alcohol drinking, use of anticoagulants or NSAIDS)

Please send questions or comments to askapharmacist@bannerhealth.com.

References:

- Grundy SM, Stone NJ, Bailey AL, et al. 2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. Circulation. 2019;139:e1082–1143.
- Ma C, Gurol ME, Huang Z, et al. Low-density lipoprotein cholesterol and risk of intracerebral hemorrhage: A prospective study. Neurology. 2019;93(5):e445.
- Sabatine MS, Wiviott SD, Im K, Murphy SA, Giugliano RP. Efficacy and Safety of Further Lowering of Low-Density Lipoprotein Cholesterol in Patients Starting With Very Low Levels: A Meta-analysis. JAMA Cardiol. 2018;3(9):823-828.

Quality: HEDIS Measures

What is HEDIS?

The Healthcare Effectiveness Data and Information Set (HEDIS) is an established set of standardized performance measures designed by the National Committee for Quality Assurance (NCQA) for the managed care industry. HEDIS Measures relate to many significant public health issues, such as cancer, heart disease, smoking, asthma and diabetes.

HEDIS measures are used by more than 90% of America's health plans to measure performance on important dimensions of care and service. They are comprised of 90 performance measures which are divided into the following categories:

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Risk Adjusted Utilization
- Health Plan Descriptive Information
- Measures Collected Using Electronic Clinical Data Systems

What is HEDIS used for?

HEDIS is helpful to both members and providers. Members can compare health plan performance to other plans as it relates to finding the services they need. Providers can use HEDIS performance data to identify areas of improvement, to track progress towards areas of improvement, and to monitor areas that are working efficiently.

Provider engagement for follow-up after Hospitalization for Mental Illness (FUH)

BH Providers are key to bridging the gap of services when a member is hospitalized. In accordance with AHCCCS and Federal regulatory requirements, BUHP is required to track HEDIS performance measures for follow up care at 7 days and 30 days after discharge to assess progress to recovery for our Adult and Children population. These timeframes are in place to help prevent hospital readmission and worsening of the member's condition.

BUHP baseline measures for FUH are 7 days-60% and 30 days-85% for both populations. As of March 2020, our current measures are under the threshold.

Adult D/C Follow-up @ 7 days	CY19 Q4 Jul-Sep	FY20 Q1 Oct-Dec	FY20 Q2 Jan-Mar	Baseline measures
	19%	21%	17%	60%
Children D/C Follow-up @ 7 days	CY19 Q4 Jul-Sep	FY20 Q1 Oct-Dec	FY20 Q2 Jan-Mar	Baseline measures
	26%	29%	29%	60%
Children D/C Follow-up @ 30 days		FY20 Q1 Oct-Dec	FY20 Q2 Jan-Mar	Baseline measures
		45%	48%	85%
Adult D/C Follow-up @ 30 days		FY20 Q1 Oct-Dec	FY20 Q2 Jan-Mar	Baseline measures
		34%	28%	85%

Helpful Tips and Information for meeting FUH timeframes and requirements

- Definition: Discharged from an inpatient admission for select mental illness diagnoses and one follow-up outpatient visit, intensive outpatient encounter, or partial hospitalization with a mental health practitioner including a BHMP and independently licensed BHP.
- The following is a reference guide for the use of services codes that qualify for FUH and support upward trend of HEDIS measures: **Follow-Up Visit Codes CPT**: 98960–98962, 99078, 99201–99205, 99211–99215, 99241–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397,99401–99404, 99411, 99412, 99510 HCPCS: G0155, G0176, G0177, G0409, G0463, H0002, H0004, H0031, H0034, H0036–H0037, H0039, H0040, H2000, H2010, H2011, H2013-H2020, M0064, T1015 UBREV: 510, 513, 515-517, 519-523, 526-529, 900, 902-904, 911, 914-917, 919, 982, 983 **TCM CPT**: 99495, 99496 CPTs that require a POS code: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99251–99255 with one of the following POS codes: 2,3,5,7,9,11-20, 22,33,49,50,52,53,71,72 **Any of the above, with or without Telehealth Monitor CPT**: 95, **GT Observations CPTs**: 99217-99220 Partial Hospital/IOP HCPCS: G410, G411, H0035, H2001, H2012, S2021, S9480, S9484, S9485 UBREV: 905, 907, 912, 913

Due to the COVID-19 pandemic, telemedicine appointments are being used to promote social distancing. HEDIS discharge follow-up appointments can be conducted by telemedicine if they are conducted within the aforementioned timeframes and by a behavioral health medical professional.

- Follow-up visits that occur on the date of discharge do not count for HEDIS!
- Maintain appointment availability at your clinic for recent hospital discharges.
- Explain the importance of follow-up to your members.
- Reach out to members that do not keep initial follow-up appointments and reschedule them ASAP.

BUHP is committed to improving the quality of life for members through an integrated approach. In order to track HEDIS measures, follow-up appointments must be completed by a qualified mental practitioner, such as a BHMP or independently licensed BHP. We encourage BH providers to maintain appointment availability for members with recent hospital discharges. Be sure to reach out to and engage members regarding the importance of their follow-up appointment. For any questions or technical support, contact BUHP Quality Management: Jennifer.Lewusz@bannerhealth.com.

Importance of Appointment Availability

As a reminder, AHCCCS has outlined their regulations for appointment availability in the AHCCCS Contractor Operations Manual (ACOM) Chapter 24 (see below). Banner works with Contact One to conduct a quarterly survey. Contact One will reach out to a representative sample of our providers to verify appointment availability. If you should receive a call from Contact One, please take the time to answer their questions. This survey is important to validate that the network meets AHCCCS and CMS standards. It also allows us to identify any actions we may need to take to improve access to our members.

GENERAL APPOINTMENT STANDARDS FOR ALL CONTRACTORS

1. For Primary Care Provider Appointments:
    a. Urgent Care Appointments as expeditiously as the member's health condition requires but no later than two business days of request, and
    b. Routine care appointments within 21 calendar days of request.

2. For Specialty Provider Appointments, including Dental Specialty:
    a. Urgent Care Appointments as expeditiously as the member's health condition requires, but no later than two business days from the request, and
    b. Routine care appointments within 45 calendar days of referral.

3. For Dental Provider Appointments:
    a. Urgent appointments as expeditiously as the member's health condition requires, but no later than three business days of request
    b. Routine care appointments within 45 calendar days of request, and
    c. For CMDP only, routine care appointments within 30 calendar days of request.

4. For Maternity Care Provider Appointments, initial prenatal care appointments for enrolled pregnant members shall be provided as follows:
    a. First trimester - within 14 calendar days of request,
    b. Second trimester within seven calendar days of request,
    c. Third trimester within three days business of request, and
    d. High risk pregnancies as expeditiously as the member's health condition requires and no later than three business days of identification of high risk by the Contractor or maternity care provider, or immediately if an emergency exists.

Referring, Ordering, Prescribing, Attending (ROPA) Providers Required to Register with AHCCCS

The Patient Protection and Affordable Care Act (ACA) and the 21st Century Cures Act (Cures) require that all health care providers who provide services to, order (refer), prescribe, or certify health care services for AHCCCS members must be enrolled as an AHCCCS provider.

Until these Acts passed, referring, ordering, prescribing and attending providers were required to obtain a National Provider Identifiers (NPIs) but were not required to be enrolled as an AHCCCS provider.

After Jan. 1, 2021 claims which include referring, ordering, prescribing or attending providers who are not enrolled with AHCCCS will not be reimbursed. AHCCCS encourages all providers who are not currently registered with AHCCCS, but who are referring, ordering, prescribing or attending providers, to register as an AHCCCS provider as soon as possible. Service providers whose claims include referring, ordering, prescribing or attending providers who are not registered with AHCCCS should work with these providers to complete their registration.

To ensure payment of claims when submitting for items and/or services attended, ordered, referred, or prescribed by another provider, the rendering provider must ensure that the ordering/referring/prescribing provider is actively registered with AHCCCS.

A provider who chooses to attend, order, refer, or prescribe items and/or services for AHCCCS members, but who chooses not to submit claims to AHCCCS directly, must still be registered with AHCCCS to ensure payment of those items and/or services where he attended, ordered, referred or prescribed.

AHCCCS has developed and posted the FAQ's outlined below.

https://www.azahcccs.gov/PlansProviders/NewProviders/ROPA.html

To begin the enrollment process, visit AHCCCS Provider Enrollment (https://www.azahcccs.gov/PlansProviders/NewProviders/registration.html)

Opioid Treatment Program Required Reporting

AHCCCS requires that all OTPs submit the following five items before November:

1. Detailed security plan
2. Neighborhood engagement plan
3. Comprehensive plan to demonstrate how the OTP ensures that appropriate medication-assisted standards of care are met
4. Community relations and education plan
5. Current diversion control plan
1. In addition, any new OTP provider must also submit the plans listed above to AHCCCS for approval prior to the provision of AHCCCS reimbursable services.

For more information, visit https://www.azahcccs.gov/Members/BehavioralHealthServices/OpioidUseDisorderAndTreatment/OTP_Requirements.html

Submit all documentation to GrantsManagement@azahcccs.gov

Compliance Corner

Informed Consent for Telehealth Services during the COVID-19 emergency Period

AHCCCS addressed the issue of informed consent requirements for services provided via telehealth or telephonic means during the COVID-19 emergency period on a March 24, 2020, update to the Frequently Asked Questions (FAQs) Regarding Coronavirus Disease 2019 page of the AHCCCS.gov website. During the emergency period, AHCCCS has waived the written informed consent requirement for telehealth and telephonic services and verbal informed consent alone will be acceptable.

Verbal informed consent should include discussion of the following items:

- Inform patients of their rights when receiving telemedicine, including the right to stop or refuse treatment.
- Tell patients their own responsibilities when receiving telemedicine treatment.

- Describe the potential benefits, constraints, and risks (like privacy and security) of telemedicine.
- Inform patients of what will happen in the case of technology or equipment failures during telemedicine sessions, and state a contingency plan.

While obtaining written consent is not required during the emergency period, it is still necessary to document verbal consent appropriately within the medical record when providing telehealth services. The documentation does not need to be extensive; it simply needs to support that a verbal discussion with the patient occurred and that the patient consented to proceed with the telehealth service. For example, a brief statement such as "services provided via telehealth (platform) after verbal consent from the patient on (date) at (time) via non-HIPAA platform" would be adequate to support verbal consent during the emergency period.

HIPAA and COVID-19

Recently there have been numerous publications by different agencies and organizations regarding HIPAA and how it relates to the rapidly evolving COVID-19 situation. Some guidance mentions "waivers" to HIPAA, suggesting that perhaps due to the unusual circumstances we are facing that HIPAA does not apply and will not be enforced.

These communications can easily be misinterpreted and there are some exceptions and limitations. Check with your Privacy Officer for guidance.

The Office of Civil Rights has several Bulletins, Notifications of Enforcement Discretion, Guidance and Resources that can help explain how member/patient health information may be utilized and disclosed in response to the COVID-19 national public health emergency. This information can be found at:

https://www.hhs.gov/hipaa/for-professionals/special-topics/hipaa-covid19/index.html

Remember that you should never post information about a member/patient on social media (including in private or closed groups) as you could be in violation of HIPAA. It's extremely difficult to anonymize a member/patient and even the most subtle information can possible re-identify someone. You should only access electronic health records of members/patients that you are treating and have a need to review.

Banner University Health Plans Contact Information

BUHP Customer Care
Banner - University Family Care – ACC (800) 582-8686
Banner - University Family Care – LTC (833) 318-4146
Banner - University Care Advantage – SNP (877) 874-3930
BUHP Compliance Officers
(520) 874-2847 or (520) 874-2553
BUHP Compliance Department FAX
(520) 874-7072
BUHP Compliance Department Email
BUHPCompliance@BannerHealth.com

BUHP Compliance Department Mail:
BUHP Compliance & Audit Dept 2701 E
Elvira Rd
Tucson, AZ 85756

Confidential and Anonymous Compliance Hotline (ComplyLine)
(888) 747-7989

AHCCCS Office of the Inspector General

Providers are required to report any suspected FWA directly to AHCCCS OIG

Provider Fraud
(602) 417-4045
(888) 487-6686

Member Fraud
(602) 417-4193
(888) 487-6686

Website
www.azahcccs.gov (select **Fraud Prevention**)

Mail:
Inspector General
701 E Jefferson St.
MD 4500
Phoenix, AZ 85034

Medicare

Providers are required to report all suspected fraud, waste and abuse to the Health Plan or to Medicare

Phone: (800) HHS-TIPS (800-447-8477)
FAX: (800) 223-8164
TYY: (800) 377-4950

Website: https://forms.oig.hhs.gov/hotlineoperations

Mail:
US Department of Health & Human Services
Office of the Inspector General
ATTN: OIG HOTLINE OPERATIONS
PO Box 23489
Washington, DC 20026

Banner Health Network

Banner University Health Plans

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

Member Perception Star Measure

Why is the survey important?

The CAHPS survey, developed by the U.S. Agency for Healthcare Research and Quality, measures the patient experience with health care services. The results contribute to the Centers for Medicare & Medicaid Services Star rating. Providing a positive patient experience improves patient outcomes and makes good business sense, according to recent studies. Research shows that a good patient experience is associated with positive clinical outcomes. Also, improvement in patient experience correlates with key financial indicators, such as lower medical malpractice risk and less employee turnover.

Survey questions and provider opportunities

Providers can have a direct impact on how the patient experience is reported on the survey. A sample of survey questions is listed below along with correlating actions providers can take to positively impact the customer experience and, in turn, impact the CAHPS scores.

Measure	Sample survey questions	Tips for providers
Getting Appointments & 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 needed? • How often did you get an appointment for routine care as soon as you needed?	• Patients are more tolerant of appointment delays if they know the reasons for the delay. When the provider is behind schedule: – Front office staff should update patients often and explain the cause for the schedule delay. – Staff members interacting with the patient should acknowledge the delay with the patient. • Leave a few appointment slots 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.

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		• Ask patients to make routine checkups and follow-up appointments in advance.
Care Coordination	**In the last six months:** • 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, how often did someone from your personal doctor's office follow up to give you those results? • When your personal doctor ordered a blood test, X-ray or other test for you, how often did you get those results as soon as you needed them? • How often did you and your personal doctor talk 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 the care you received from specialists?	• Before walking in the exam room, review the reason for the visit and determine if you need to follow up on any health issues or concerns from previous visits. • Implement a system in your office to ensure timely notifications of test results and communicate clearly with patients on when and how they'll receive test results. • Review the patient's current medication list with the patient and ask open-ended questions to reveal barriers; ask if they have any concerns or questions about their current prescribed medications. • Ask your patients if they saw another provider since you last saw them. If you know patients received specialty care, discuss their visit and the treatment plan they received, including any newly prescribed medication. • Upon check out, make sure the patient is educated on follow-up issues (i.e. prescriptions, referrals, authorizations, etc.).
Rating of Health Care Quality	Using any number between zero and 10, where zero is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last six months?	• Ask patients how you can help improve their health care experience.
Getting Needed Prescription Drugs	**In the last six months:** How often was it easy to use your prescription drug plan to get the medicines your doctor prescribed?	• Select preferred products from your patients' drug plan formulary. • Ensure timely responses for prior authorization requests; proactively submit when possible. • Encourage the use of mail order pharmacies for the lowest patient cost and convenient delivery services.

If you have additional questions, please contact your Provider Relations Representative.

References: *Agency for Healthcare Research and Quality, Centers for Medicare & Medicaid Services*

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