First Choice VIP Care Program Overview

A Quick Guide to Understanding the First Choice VIP Care Plan

FirstChoice VIP CARE
by Select Health of South Carolina

Model of Care (MOC)

A Quick Guide on the Model of Care

FirstChoice VIP CARE
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Model of Care Annual Training Requirement

First Choice VIP Care is a type of Medicare Advantage plan known as a Dual Eligible Special Needs Plan (D-SNP), meaning we only enroll individuals who are entitled to both Medicare and medical assistance from a state plan under Medicaid.

As a D-SNP, First Choice VIP Care is required by the Centers for Medicare and Medicaid Services (CMS) to develop a Model of Care (MOC). We are also required to provide annual training of the MOC, and providers who care for our beneficiaries are required to complete and attest to receiving this training.

Model of Care Annual Training Requirement (Continued)

Providers may receive training in the following ways:

- In person from a training seminar or a Network Management Account Executive.
- Access an online Model of Care training module on our website, www.firstchoicevipcare.com, under the Provider Training and Education link.
- Review faxed Model of Care training materials.
- Receive or request printed Model of Care training materials from your Network Management Account Executive.

Providers may attest to completing the training through the online attestation form found at: https://www.surveymonkey.com/r/FirstChoiceVIPCareMOCAttestation

What Is the Model of Care?

The Model of Care (MOC):

- Provides the basic framework under which our D-SNP will meet the needs of each of our enrollees.
- Is a vital quality improvement tool and integral component for ensuring that the unique needs of each enrollee are identified and addressed through our care management practices.
- Provides the foundation for promoting D-SNP quality, care management, and care coordination processes.

What Is the Model of Care? – Simplified

The Model of Care is First Choice VIP Care's

Model of how we **Care** for our Dual Eligible members.

Model of Care — Why First Choice VIP Care Was Created

The D-SNP, First Choice VIP Care, was created to offer Medicare and Medicaid eligible beneficiaries the opportunity to receive coordinated benefits to more efficiently and effectively manage their care.

The goals of creating this plan were to:

- Improve health outcomes.
- Keep beneficiaries in the community.
- Provide enhanced benefits in addition to Medicare and Medicaid benefits.

How is this accomplished?

Through the Model of Care.

Why the Model of Care Is Necessary

- There are approximately 12 million dual eligibles in the United States.
- They are more sick and frail than the general Medicare population.

Population	Percent of Population	Percent of Dollars Spent
Medicare	21%	31%
Medicaid	15%	39%

Model of Care - How Medicare-Medicaid (Dual) Eligibles Are Different From the General Medicare Population

They are:

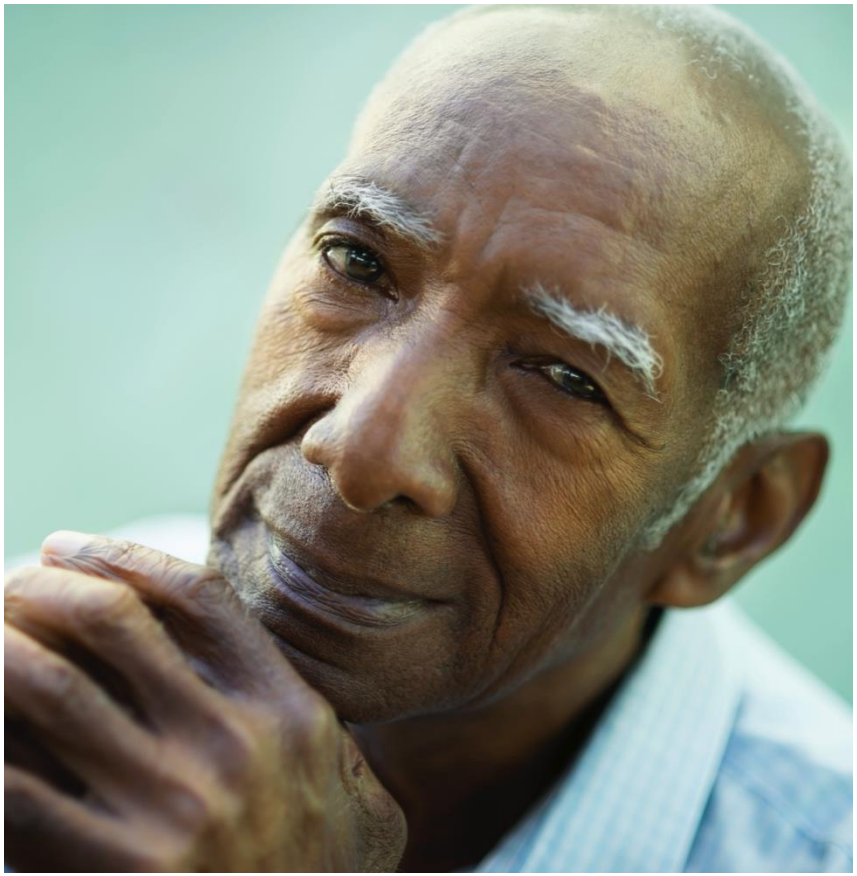
- Three times more likely to live with a disabling condition.
- More likely to have greater limitations in activities of daily living (ADLs), such as bathing and dressing.
- More likely to suffer from cognitive impairment and mental disorders.
- Indicated to have higher rates of pulmonary disease, diabetes, stroke and Alzheimer's disease.
- More likely to be in need of in-home care providers, plus a range of doctors and other health and social services, due to these high health needs.

Medicare Payment Advisory Commission (MedPAC). *Report to Congress: New Approaches in Medicare,* Chapter 3: Dual Eligible Beneficiaries, an Overview, June 2011.

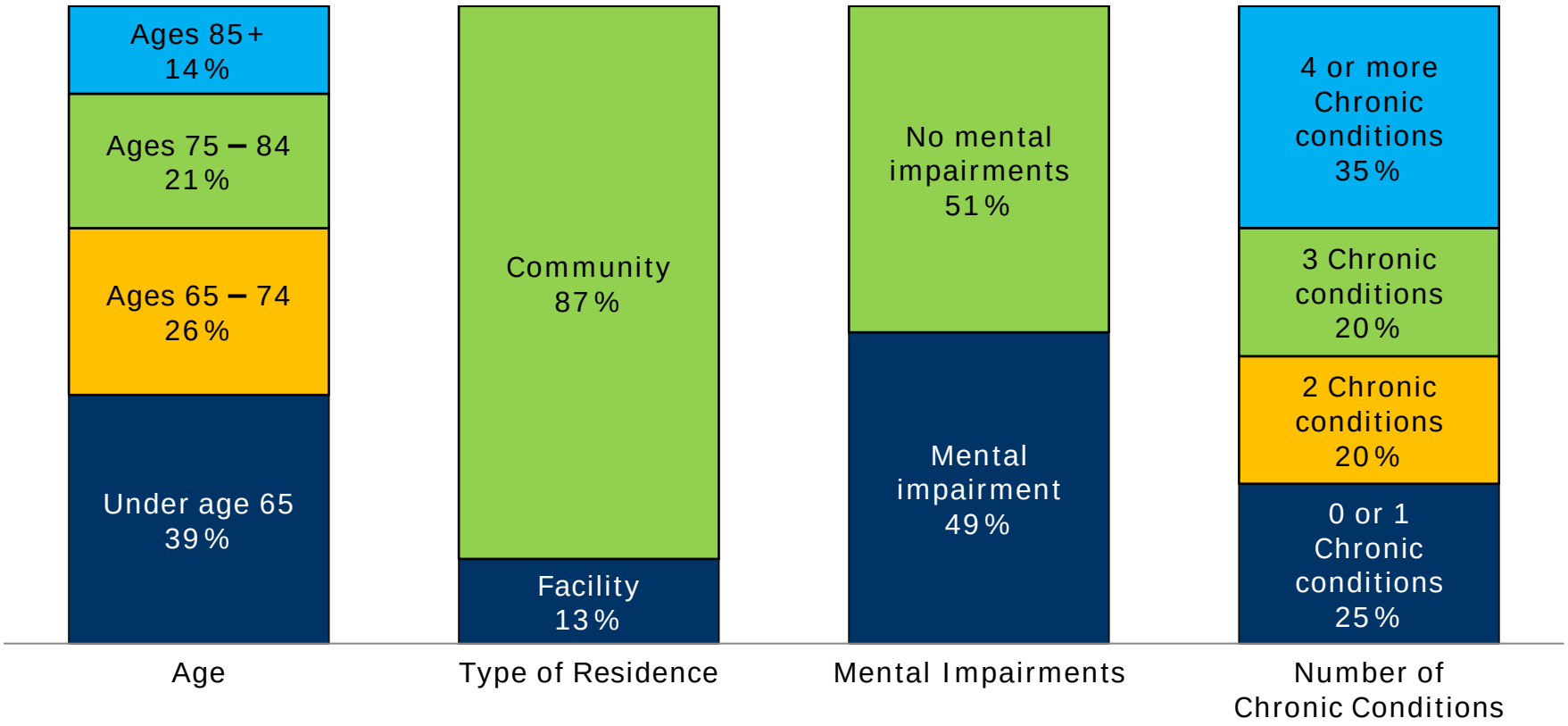
Model of Care — Outlining the High Volume = High-Cost Issue in the Dual-Eligible Population

Issues in the dual-eligible population that increase costs include:

- Frequent emergency room (ER) visits.
- Readmissions to hospital.
- Long-term skilled nursing facility stays.
- Poor medication adherence.



Model of Care — Why Dual Eligibles Are Special-Needs Members



Note: **Mental impairments were defined as Alzheimer's disease, dementia,** depression, bipolar, schizophrenia or intellectual disability.
Source: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey, 2008.

Building the Model of Care Interdisciplinary Care Team

An integral part of the MOC is building an Interdisciplinary Care Team (ICT). This begins with the development of First Choice VIP Care's ***Care Team***. Both the providers and members have access to this team which helps members modify their behavior and how they access health care.

The First Choice VIP Care ***Care Team*** includes:

- ✓ Care Connectors
- ✓ Concierge Team
- ✓ Care Managers

First Choice VIP Care *Care Team* Roles & Responsibilities

Care Connectors/Concierge Team

All Customer Service Functions:

- Schedule and remind members of appointments.
- Remind members during gaps in care.
- Support member education.
- Link member to health and social service systems.
- Coach for behavior change and condition management education.
- Help with basic navigation, such as shopping and transportation.
- Triage urgent needs.

Care Manager

All Clinical Functions:

- Perform Health Risk Assessments.
- Assist in the development of individual Care Plans (ICP).
- Participate on the Integrated Care Team (ICT).
- Communicate with PCPs to share information, coordinate care and promote timely treatment.
- Coach for behavior change and condition management education.
- Coordinate transitions.

Work together to support the member

How the Care Team Helps Members

The Care Team understands the most common diagnosis is poverty.

- Help address limited resources in all aspects of a member's life that will impact medical care and costs.
- Build trusted relationships.
- Monitor changes in condition.
- Advocate for the member.
- Overcome barriers to better adherence to medication and self-care regimes.

The Care Team knows that transitions of care are major events.

- The Care Team is involved in assisting the member and the provider with managing the details across settings to prevent readmissions.

The Care Team knows that caregiver involvement is critical.

- The Care Team helps identify capable resources (such as friends, family and agencies) who can provide members with better care and the Care Team with a more objective perspective.

Continuing to Build the Model of Care ICT

The IT is crafted to serve the individual needs of each member by collaborating/communicating to develop and update the ICP and by managing medical, cognitive and psychosocial needs of members. The team is comprised of the First Choice VIP Care *Care Team* along with the following, if applicable:

- The member.
- The primary care provider or medical home.
- Health plan nurses, medical directors and pharmacists.
- Physical and behavioral health specialists.
- Home health care providers.
- Social workers.
- Community mental health workers.
- Physical, speech and occupational therapy providers.
- Others who play an important role in their care - family members, friends, pastor, etc.

ICT and the Primary Care Provider/Medical Home's Roles

The primary care provider/medical home is the main provider responsible for overseeing the overall care of the member. The key responsibilities of this role include:

- Helping members determine which services they need.
- Connecting members to the appropriate services.
- Serving as a central communication point for the member's care.
- Reviewing the plan of care sent by First Choice VIP Care.
- Providing feedback to First Choice VIP Care.

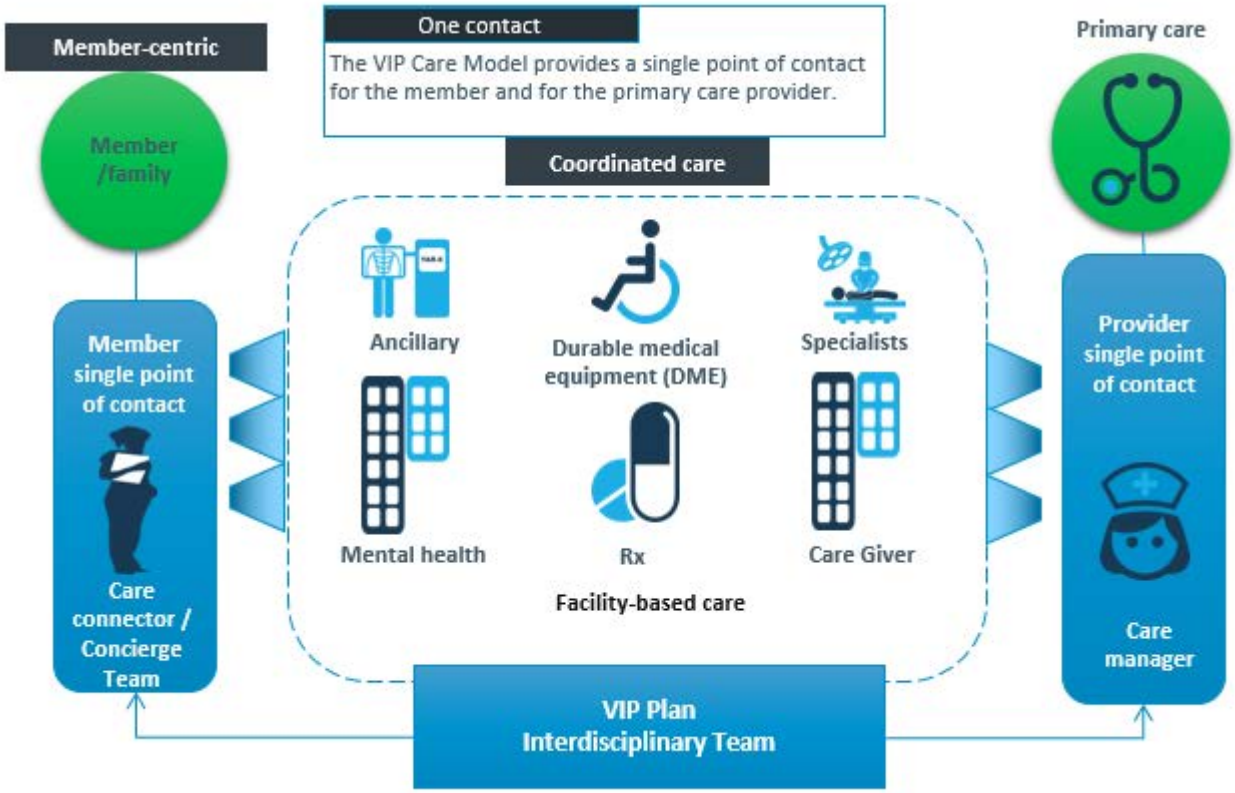
Model of Care — Plan Implementation Overview

1. Each member enrolls with a primary care provider/medical home.
2. The Health Risk Assessment (HRA) will be completed by the member on the phone with a care manager. The assessment is used to collect member information regarding:

    - **Physical and behavioral health history.**
    - **Preventive care.**
    - **Level of activity.**
    - **Medication use.**

3. An Individual Care Plan is developed which includes care and support from health care providers, community agencies and service organizations.
4. The Integrated Care Team coordinates and arranges care for the member as needed.
5. The care manager will contact each member annually to encourage them to update the HRA.

Model of Care — How the Model of Care Creates a Single Point of Contact for the Member and Primary Care Physician to Achieve Coordinated Care



ICT:

- Member.
- PCP.
- Specialists
- Medical director.
- Care manager/CHW.
- Member/family.
- Housing coordinator.
- Pharmacist.
- Behavioral health.
- Other community agencies.

Model of Care – Other Components

Model of Care — A Model of Care Success Story

"Ms. Smith" is a single woman in her 70's who lives independently in an apartment building in Philadelphia. She has been a member of one of our VIP plans since early 2015. Her main health concerns are anxiety, atrial fibrillation, and alcohol abuse.

Ms. Smith has no close family members but does have a few friends. When a nurse Care Manager (CM) first began working with this member, the member was drinking to the point of having blackouts out on a daily basis. The alcohol abuse was aggravating the member's heart condition. In addition, the member had received a letter that she was in danger of being evicted from her building due to her behaviors. In just six months, Ms. Smith experienced 10 trips to the hospital emergency department and four inpatient hospitalizations. Her providers were becoming frustrated because they were not able to help her improve her health.

Model of Care — The Vision of How the Model of Care Should Work

How did the Care Manager help:

- She reached out to the member several times each week to discuss the negative health effects of the member's heavy drinking, and provide emotional support.
- She consulted and collaborated with an internal Social Worker CM to provide additional help for the member with her addiction and other behavioral health issues.
- The Social Worker CM partnered with the CM to provide support to the member when the member's usual CM was not available.

Model of Care — The Results of the Model of Care

After several months, we saw positive results. The member:

- She began attending AA meetings and seeing her therapist on a regular basis.
- She stopped drinking all-together and was participating in and enjoying activities again.
- She started going to the gym several times a week and traveled to the shore to sit on the beach and relax.
- She began to pay closer attention to eating a healthy diet as well.
- She did not need to go to the emergency department and had no inpatient admissions for more than 6 months.

Model of Care — Living the Mission of the Model of Care

The CM continued to build rapport and check in with the member periodically, but the member had few health needs during her time of recovery. Member often stated how much she appreciated the calls and how she felt so much better just talking with the CM and sharing her life issue. Ms. Smith stated it meant a lot knowing that someone cared.

Model of Care — Continuing to Live the Mission of the Model of Care

Continuing management of our members:

- More recently, Ms. Smith did have a relapse in her alcohol abuse, and she again experienced negative physical effects that brought her to the ER and have an inpatient admission.
- Her SW CM reached out to her and member felt comfortable sharing her relapse and how she was feeling about her recent life events.
- Upon CM's advice and support, member increased her visits with her BH therapist. The member was willing to recommit to a healthier lifestyle, as well as to exploring alternative treatments for her anxiety, such as meditation.
- After several weeks had passed, the CM spoke with Ms. Smith. The member had not relapsed and was keeping up with all of her medical appointments and health practices.

Through the consistent and supportive communication with the Care Managers, Ms. Smith was able to quickly reverse her relapse and return to a more healthy lifestyle.

Eligibility

A Quick Guide to Understanding the First Choice VIP Care Member Eligibility

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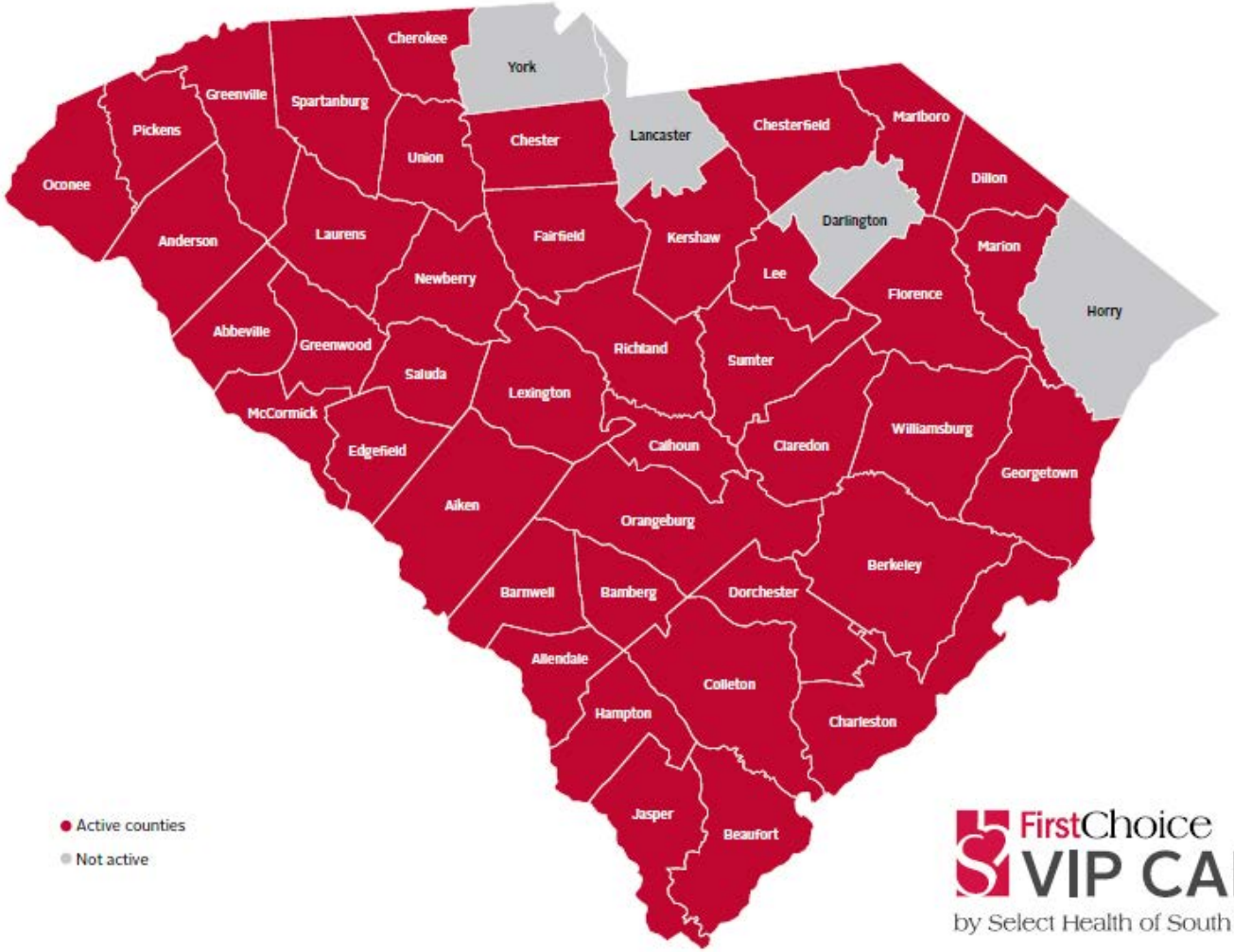
Member Eligibility Requirements

Members are eligible to enroll in First Choice VIP Care if they are:

- Entitled to Medicare Part A, and enrolled in Medicare Part B.
- Live in our service area.
- Enrolled in the Healthy Connections Medicaid program.

However, Individuals with end-stage renal disease (ESRD) generally are not eligible to enroll in First Choice VIP Care unless the individual meets exceptions to ESRD eligibility rules outlined in Chapter 2, Section 20.2, of the CMS Medicare Managed Care Manual.

First Choice VIP Care Service Area



Member Eligibility – Medicare Savings Program

Some individuals can get help from the State in paying their Medicare premiums. In some cases, Medicare Savings Programs may also pay Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) deductibles, coinsurance, and copayments if certain conditions are met.

First Choice VIP Care covers individuals who are in the following programs:

Eligibility Category	Coverage	Pays For
Qualified Medicare Beneficiary (QMB)	Medicare **without** full Medicaid	Helps pay for Part A & B premium and deductibles, coinsurance, and copayments.

Member Eligibility — Why Verifying Member Eligibility Is Critical for Providers and Members

Since members can change plans quarterly, providers must verify the eligibility of their patients at each encounter. Some key benefits to checking members' eligibility are:

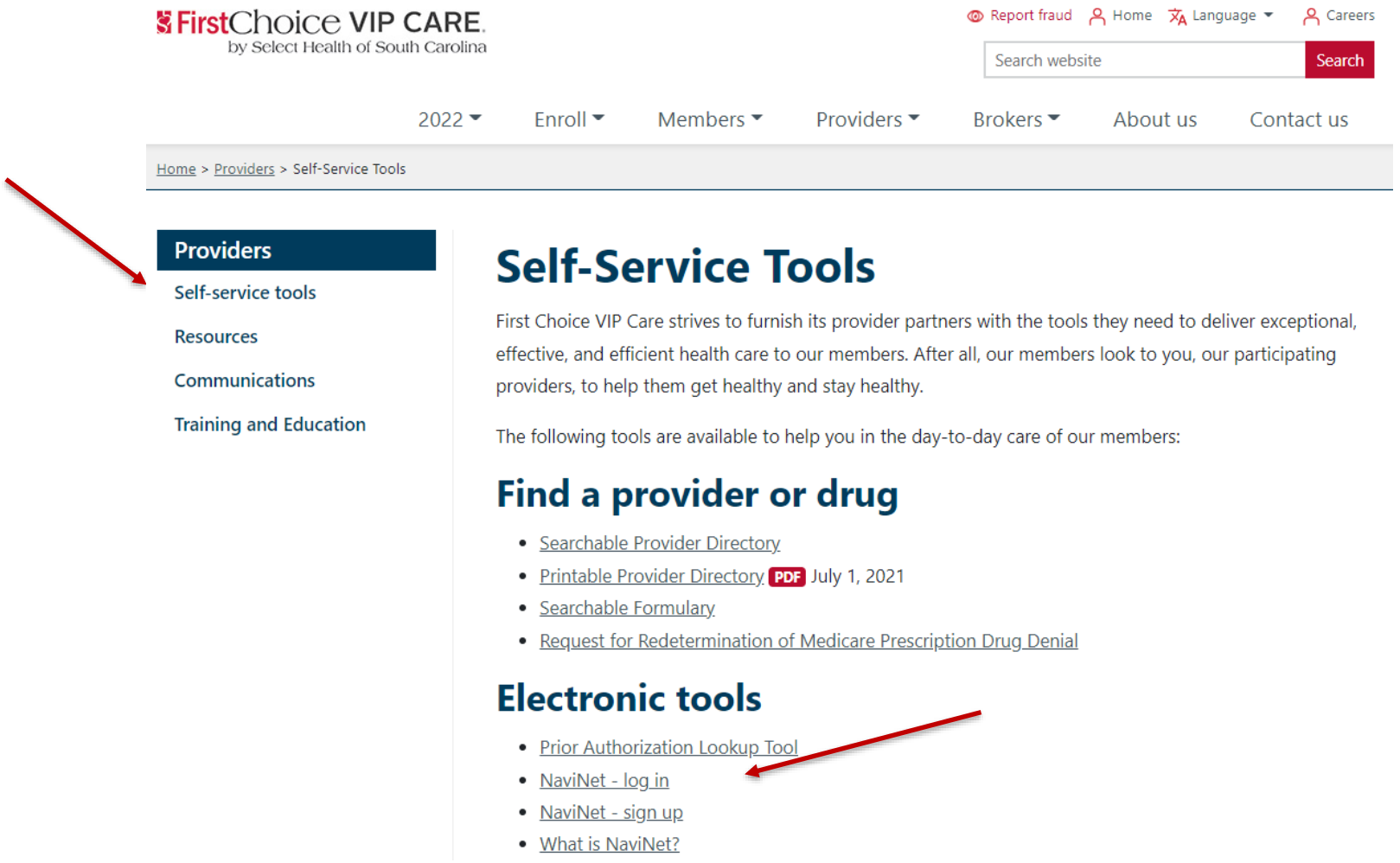
- Ensuring the member is seeing the appropriate provider.
- Reducing claim issues because you are sending the claim to the right plan.

Member Eligibility — Three Ways to Verify Member Eligibility

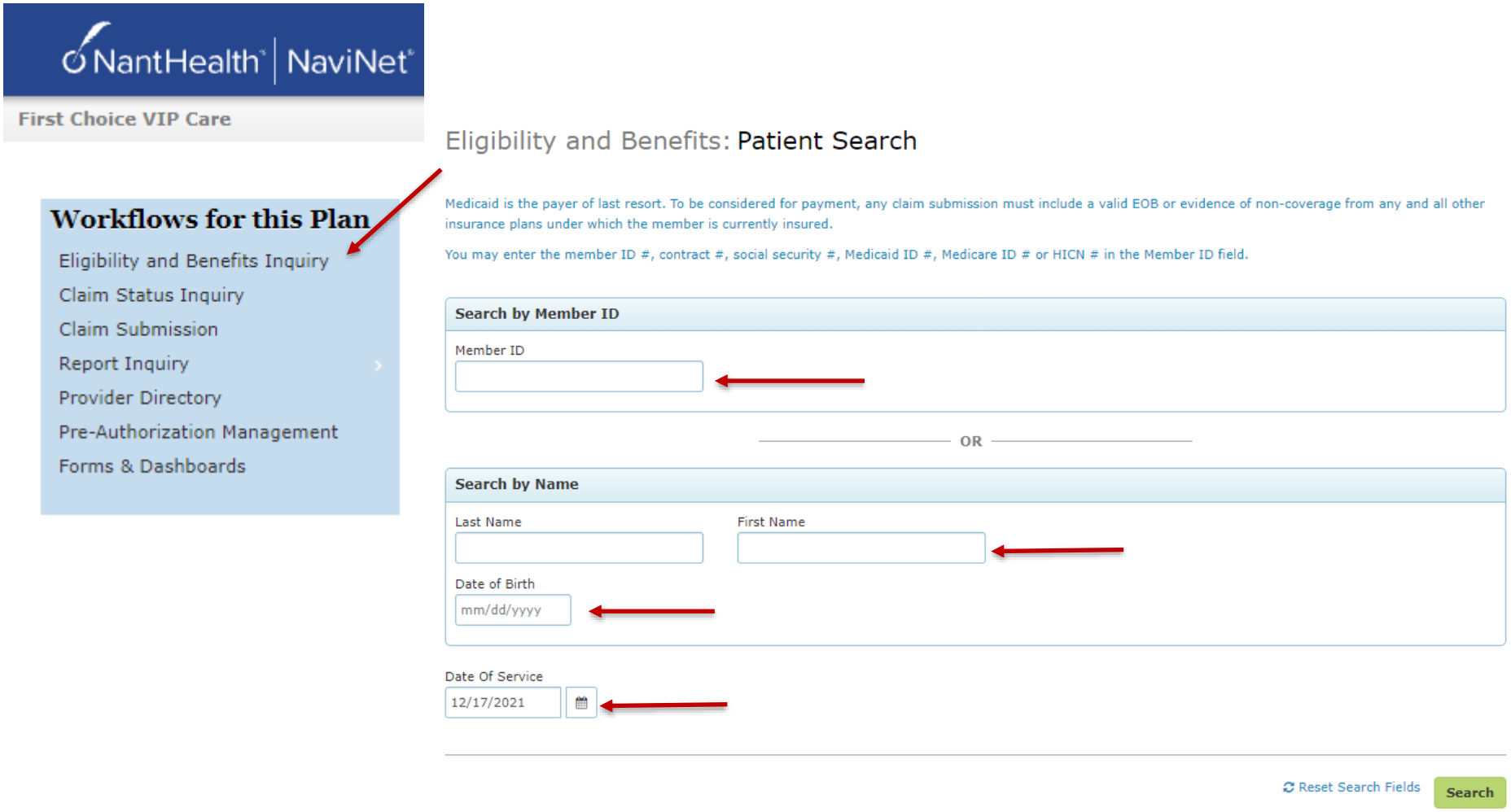
Providers can verify members' eligibility by:

- Calling Provider Services at 1-888-978-0151.
- Visiting our website at www.firstchoicevipcare.com and accessing NaviNet.
- Using the member identification card. However, a member's ID card is not a guarantee of eligibility.

Member Eligibility — Using NaviNet to Verify Eligibility
(Log on Directly or From the First Choice VIP Care Provider Page)



Member Eligibility — Using NaviNet to Verify Eligibility



Member Eligibility — Member ID Card

Member Information

PCP Information

Health Plan Contact and Claim Filing Information

No Balance Billing Information

Prescription Drug Information

Member Eligibility — Helpful Tips

The following is a list of helpful tips to keep in mind when determining a member's eligibility:

- Obtain the Healthy Connections Medicaid ID card for secondary payment.
- First Choice VIP Care is not a Medicare supplement.
- Verify eligibility before each visit – Dual eligible beneficiaries are in a Special Enrollment class and can change plans more frequently than non-duals.
- Make sure the correct primary care physician (PCP) is listed on the member's identification card.

D-SNP Benefits

Quick Guide to Understanding the First Choice VIP Care D-SNP Benefits

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Benefits — First Choice VIP Care Benefits Overview

First Choice VIP Care provides coverage for:

- Medicare Parts A and B.
- Medicare Part D prescription drug benefits.
- Supplemental benefits.
- Coordination of the care of members who are receiving Medicaid benefits from the State.

Benefits — Medicare vs. Medicaid: Which Program Pays for Which Service?

Plan name	Medicare Parts A and B	Medicare Part D	Medicaid
Medicaid – South Carolina Department of Health and Human Services - Health Connections	N/A	N/A	✓
Medicare Advantage	✓	✓	Not applicable for non-dual-eligible Medicare beneficiaries Healthy Connections Medicaid for dual-eligible beneficiaries
Dual-eligible Special Needs Plans (D-SNP) **First Choice VIP Care**	✓	✓	Healthy Connections Medicaid

Benefits — Medicare Part A and B Benefits*

- Ambulance services.
- Cardiac and pulmonary rehabilitation services.
- Catastrophic coverage.
- Chiropractic care.
- Dental services.
- Diabetes program and supplies.
- Diagnostic tests, X-rays, lab services and radiology services.
- Doctor office visits.
- Durable medical equipment.
- Emergency care.
- Hearing services.
- Home health care.
- Inpatient hospital care.
- Inpatient mental health care.
- LTC pharmacy.
- Mail order prescriptions.
- Out-of-network catastrophic coverage.
- Out-of-network catastrophic prescriptions.
- Out-of-network initial coverage.
- Outpatient mental health care.
- Outpatient prescription drugs.
- Outpatient rehabilitation.
- Outpatient services and surgery.
- Outpatient substance abuse care.
- Pharmacy.
- Podiatry.
- Preventive services and wellness education.
- Prosthetic devices.
- Skilled nursing facility services.
- Urgent care.

*Exceptions may apply, see provider manual for full list of benefits. Prior authorization may be required.

Benefits — Supplemental Benefits

Dental services

Preventive dental:

- Oral exams: one every six months.
- Cleaning: one every six months.
- Fluoride treatment: one every six months.
- Dental X-rays: four every year.
- Unlimited.

Comprehensive dental:

- Non-routine services.
- $3,000 limit every year.
- Coverage for minor restorations.
- Fillings, simple extractions, dentures, denture repairs, surgical extractions, oral surgery, periodontics, endodontics, crowns, and mini-implants.

Hearing services

- One routine hearing exam every year.
- Three hearing aid fittings every three years.
- 80 batteries per aid for non-rechargeable models every three years.
- $1,500 allowance for hearing aids every three years.

Vision services

- Up to one supplemental routine eye exam every year.
- Up to one pair of eyeglasses or contact lenses every year – $350 limit.

Fitness center membership

- SilverSneakers® is a free fitness benefit which includes access to participating SilverSneakers fitness facilities, online wellness resources, and classes.

Benefits — Supplemental Benefits (Continued)

Telemedicine

- MDLive offers all members 24/7 access throughout the year to a participating doctor via telephone, desktop, or mobile device.
- Members can immediately have a medical, counseling, or psychiatry consultation with a physician.

Transportation services

- Must be plan-approved location.
- Unlimited trips per year to a plan-approved location.
- Car, shuttle and van services include non-emergent transportation to doctor visits, preventive services, pharmacies and fitness centers.
- Authorization and scheduling rules apply.
- Members may call Member Services at 1-888-996-0499 or their care managers to arrange transportation.

Over the counter (OTC)

- Typically includes medicines or products that alleviate or treat injuries or illness.
- May use the benefit without a statement or documentation of a diagnosis from a medical provider.
- Up to $250 every three months.
- No rollover quarter to quarter.
- Member may fill out OTC Catalog or call Member Services at 1-888-996-0499 to order OTC products.

Podiatry Services

- Nine routine foot care visits every year.

Benefits — Supplemental Benefits (Continued)

Meal Benefit and COVID-19 Meal Benefit

- 14 meals/week for 4 weeks for qualified homebound members after discharge from an inpatient facility or a skilled nursing facility.

Worldwide Emergency/Urgent Coverage

- $50,000 combined annual maximum.

Additional Smoking and Tobacco Use Cessation

- Four additional face-to-face PCP visits for smoking/tobacco cessation annually.

Nurse Hotline

- If members are unable to reach their PCPs' offices, registered nurses are available 24 hours/7 days a week to assist members through the toll-free First Choice VIP Care Nurse Call Line at 1-855-707-0850.

Benefits — Supplemental Benefits (Continued)

Care Team

The Care Team consists of Care Coordinators, Concierge Team, and Care Managers (nurses and social workers) trained to help members investigate and overcome barriers to achieve their health care goals. Outreach services include:

- Contacting members.
- Educating members.
- Calling providers.
- Calling pharmacies.
- Completing surveys and assessments to support special projects.

Providers may request CMT support directly by calling toll-free: 1-888-978-0151, 8 a.m. – 5 p.m., Monday through Friday.

Benefits — Additional Information

We are here to help our members find the services they need. Whether it is a Medicare or Medicaid covered service. Additionally, even if it is a non-covered service our Care Team can assist members in locating the service at a reduced or no cost.

For additional information on benefits, please refer to the Provider Manual or call Provider Services at 1-888-978-0151.

Prior Authorization/Organization Determination

A Quick Guide on the Importance and Process of Requesting a Prior Authorization/Organization Determination

FirstChoice VIP CARE
by Select Health of South Carolina

Prior Authorizations — Benefits of Using Prior Authorizations

Prior authorization:

- Ensures the patient receives the right care for the right condition.
- Helps identify members who may not be engaged in the Care Management process.
- Provides a better picture for the Interdisciplinary Care Team, enabling them to develop/update comprehensive care plans.

Prior Authorization Lookup Tool

Use our Prior Authorization Lookup Tool to find out if a service needs prior authorization. It's as easy as 1, 2, 3:

1. Locate the Lookup Tool on our website under Provider > Resources > Prior Authorization.
2. Type a Current Procedural Terminology (CPT) code or a Healthcare Common Procedure Coding System (HCPCS) code in the space provided:

   Enter CPT/HCPCS code

3. Hit submit.

This tool provides general information for outpatient services performed by a participating provider. The following services always require prior authorization:

- Elective inpatient services.
- Urgent inpatient services.
- Services from a nonparticipating provider.

The results of this tool are not a guarantee of coverage or authorization. All results are subject to change in accordance with plan policies and procedures and the Provider Manual.

Prior Authorizations — Where to Submit Organization Determination Requests

Medical services (excluding certain radiology):

- Call the prior authorization line at 1-877-375-4460.
- Complete the one of the following forms found on our website and fax to 1-833-512-1700:
  - Prior Authorization Request Form
  - Skilled Nursing Facilities Prior Authorization Form
  - Clinical Review for Outlier Days to Original DRG Approval Request Form – To request outlier days beyond originally approved DRG
- You may also submit a prior authorization request via NaviNet.

Behavioral health services:

- Call 1-866-426-7690
- Complete one of the following forms and fax to 1-844-211-0972:
  - Behavioral Health Outpatient Treatment Request Form
  - Behavioral Health Clinical Fax Form
  - Neuropsychological and Psychological Testing Request Form

Prior Authorizations — Where to Submit Organization Determination Requests Cont.

Radiological Services:

For the following non-emergent outpatient radiological procedures contact National Imaging Associates, Inc. (NIA) at 1-800-424-4788 or visit www.radmd.com:

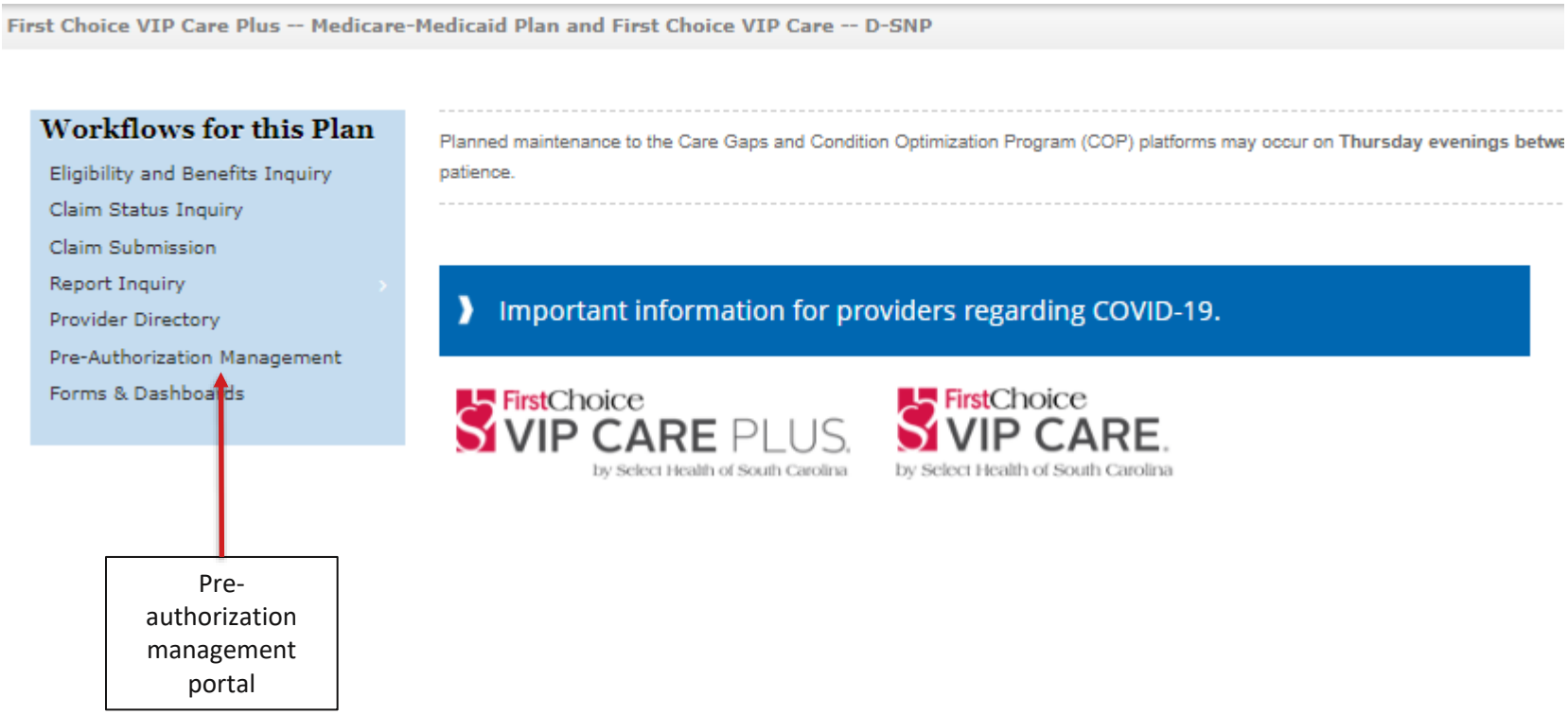
- CT/CTA
- CCTA
- MRI/MRA
- PET Scan
- Myocardial Perfusion Imaging
- MUGA Scan

Pharmacy Services

For prescription drugs not found on our formulary, an exception can be requested by completing the following:

- Request for Medicare Prescription Drug Coverage Determination Form
- Request for Medicare Prescription Drug Coverage Determination Form – Online

Prior Authorizations - NaviNet Portal



Prior Authorizations — Time Frames

- First Choice VIP Care has up to fourteen (14) calendar days to complete a standard request for prior authorization and notify the provider of the organization's determination.
- First Choice VIP Care has seventy-two (72) hours to complete an expedited request.
- Once an authorization is processed, the First Choice VIP Care provider will receive a phone call and a fax alerting him or her to the organization's determination.
- Peer-to-peer process:
  - ✓ Preservice requests – Must be requested during initial outreach by the Clinical Care Reviewer notifying the provider that the request is not meeting for medical necessity and will be pended to the Medical Director for determination. The peer to peer must occur before the whole or partial denial determination is rendered.
  - ✓ Inpatient requests –
    - ➢ Anytime during the inpatient stay.
    - ➢ Within 5 business days of the verbal/faxed denial notification or up to 5 business days after the member's discharge date, whichever is later.
  - ✓ Retrospective requests – Up to 5 business after a determination has been rendered.

Prior Authorizations — Organization Determination Process

- If the request is partially or fully denied, the member receives an Integrated Denial Notice from First Choice VIP Care, alerting the member of his or her appeal rights. Providers will also receive this notice for informational purposes.
- Refer to sections five (5) and six (6) of the First Choice VIP Care Provider Manual or the Provider section on the First Choice VIP Care website for more information.
- Please note: Providers may NOT use the Advanced Beneficiary Notice of Non-coverage (ABN) Form CMS-R-131 with Medicare Advantage plans.

Prior Authorizations – How to Prevent Appeals

Many times, the appeal process can be prevented by doing the following:

1. Providing all supporting documentation at the time of request or upon our request for additional information before the allowed authorization timeframe (14 days or 72 hours) elapses.
2. Accept the request for a peer-to-peer review at the time it is offered. Please note, it will be scheduled for a later date.
3. Provide updates to existing authorizations if the member's status changes, which may affect the original authorization.
4. For pharmacy authorizations respond to Requests for Information (RFI) within 24 or 72 hours of the date of receipt of the request depending on whether the request is urgent or standard, respectively.

Partial List of Services That Require Prior Authorization and/or Organization Determination*

- All out-of-network services (excluding emergency services).
- All inpatient hospital admissions, including medical, surgical, skilled nursing, and rehabilitation.
- Elective transfers for inpatient and/or outpatient services between acute care facilities.
- Inpatient services.
- Surgery.
- Surgical services that may be considered cosmetic.
- Transplants, including transplant evaluations.
- Certain outpatient diagnostic tests.
- Radiology outpatient services (**authorized by NIA**)
- Ambulance:
    - Elective/nonemergent air ambulance transportation.
    - Certain types of scheduled, nonemergency ambulance trips.
- Home health.
- Durable medical equipment (DME):
    - All DME rentals and rent-to-purchase items.
    - Purchase of all items in excess of $500 in total allowable charges.
    - Prosthetics and orthotics in excess of $500 in total allowable charges.
    - The purchase of all wheelchairs (motorized and manual) and all wheelchair accessories (components), regardless of cost per item.
- Cardiac and pulmonary rehabilitation.
- Speech therapy, occupational therapy, and physical therapy provided in home or outpatient setting, after the first visit, per therapy discipline/type.
- Medications: All infusion/injectable medications listed on the Medicare Professional Fee Schedule — infusion/injectable medications not listed on the Medicare Professional Fee Schedule are not covered.
- Pain management — external infusion pumps, spinal cord neurostimulators, implantable infusion pumps, radiofrequency ablation, and injections/nerve blocks,
- Nutritional supplements.
- Hyperbaric oxygen.
- Religious Non-Medical Health Care Institutions (RNHCI).
- All “miscellaneous”, “unlisted”, or “not otherwise specified” codes.
- All services that may be considered experimental and/or investigational.

For services not typically covered under Medicare, providers must still request an organization determination.

*** Exceptions apply. For a full list of services that require prior authorizations, please refer to the Provider Manual or call Care Management.**

Services That Do Not Require Prior Authorization

- Emergency services.
- Women's health specialist services (to provide women's routine and preventive health care services).
- Low-level plain films – i.e. x-rays, etc.
- EKGs.
- Post stabilization services (in-network and out-of-network).
- Imaging procedures related to emergency room services, observation care and inpatient care.
- Laboratory services.
- Ultrasounds.

Claims

A Quick Guide on the Importance and Process of Handling Claims and Encounter Submissions

FirstChoice VIP CARE
by Select Health of South Carolina

Claims – The Benefits of Using Electronic Claims and EFT

- Electronic claim submission has been proven to significantly reduce costs. Claims are processed faster; consequently, payments arrive faster.
- Enrolling in Electronic Funds Transfer (EFT) has many advantages:
  - Cash flow advantages knowing payments will be made automatically on specific dates.
  - Eliminates lost, stolen, or delayed checks sent in the mail.
  - Decreases administrative costs and increases convenience with no trips to the bank to make deposits during office hours.
  - Allows you to keep your preferred banking partner.
  - Safe and secure.
  - Reduces paper.
  - EFT is FREE.

Claims – How to Sign Up for Electronic Services Through Change Healthcare

First Choice VIP Care partners with Change Healthcare to provide free electronic claims submission.

- Claims can be submitted electronically through Change Healthcare, or another clearinghouse.
- Contact your Practice Management System Vendor or EDI clearinghouse to inform them that you wish to initiate electronic claim submissions to First Choice VIP Care.
- Providers are not required to enroll with Change Healthcare to submit electronic claims if they are already using another EDI vendor to submit claims electronically.
- Change Healthcare's toll-free number is 1-877-363-3666.
- First Choice VIP Care's Payer ID is **32456**.

Claims — Direct Entry Claims Submissions

Providers can submit claims directly to Change Healthcare through WebConnect. This service provides two methods for submitting claims:

- Key them in manually or import batches of claims.
- There is no cost to manually key claims in using WebConnect, but claims must be entered one at a time.
- For practices with high claim volume batches of claims may be imported via WebConnect, but there is a one-time setup fee of $300 for this service.
- Providers should call 1-877-667-1512 and follow the appropriate prompts or go to Change Healthcare ConnectCenter to enroll for direct submission. Change Healthcare will also provide information on their various electronic solutions, the requirements for connectivity, and setup instructions
- Providers may also access WebConnect from our website or NaviNet.

Enrolling with Change Healthcare for EFT

In order to sign up for EFT through Change Healthcare please complete an enrollment form available on their website:

https://www.changehealthcare.com/support/customer-resources/enrollment-services/medical-hospital-eft-enrollment-forms

Please note, in order to complete the enrollment form, you will need your First Choice VIP Care provider number, which can be found on the paper remit. This number will be required to fill in the Trading Partner ID field on the enrollment form. If you cannot locate your provider number, please contact First Choice VIP Care Provider Services at 1-888-978-0151.

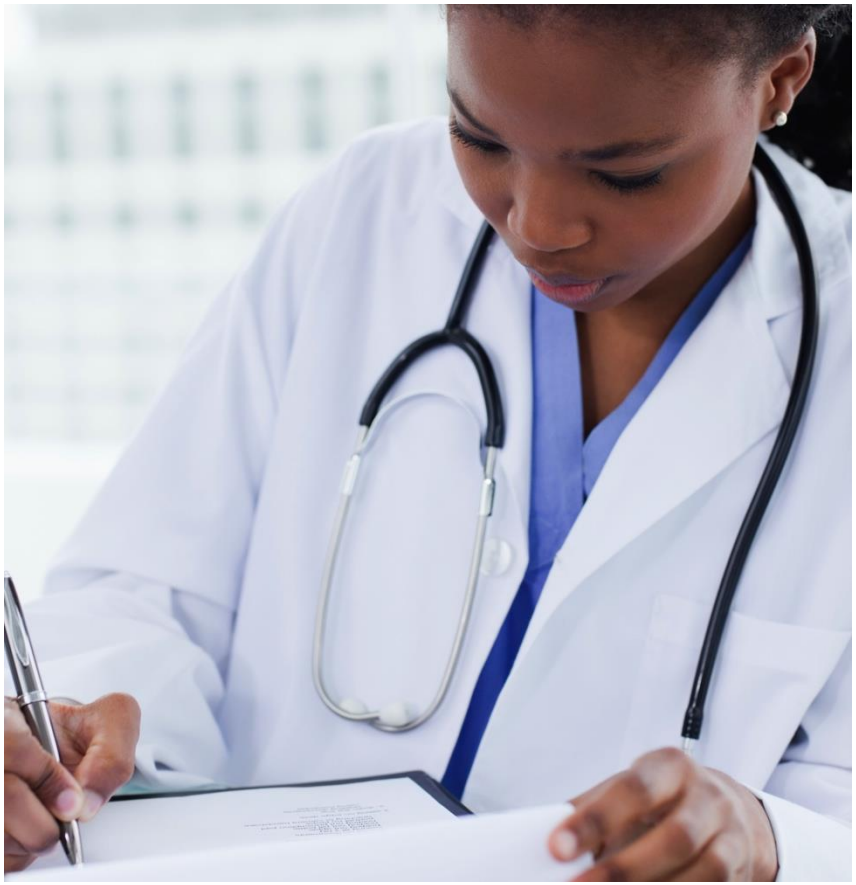
Enrollment for Electronic Remittance Advices (ERA) is also available at this link.

Claims - How to Submit Paper Claims

Providers may submit new and corrected paper claims to:

First Choice VIP Care
Claims Processing Department
P.O. Box 7182
London, KY 40742-7182

Note: Medicaid-only services and appropriate secondary payments (such as part A/B deductibles and coinsurance) should be sent to Healthy Connections Medicaid.



Claims — Claims Processing Time Frames

- First Choice VIP Care processes electronic claims in fourteen (14) calendar days and paper claims in thirty (30) calendar days.
- Providers have 365 days from the date of service to submit claims.
- Real-time claim status is available via NaviNet or by calling Provider Services at 1-888-978-0151.

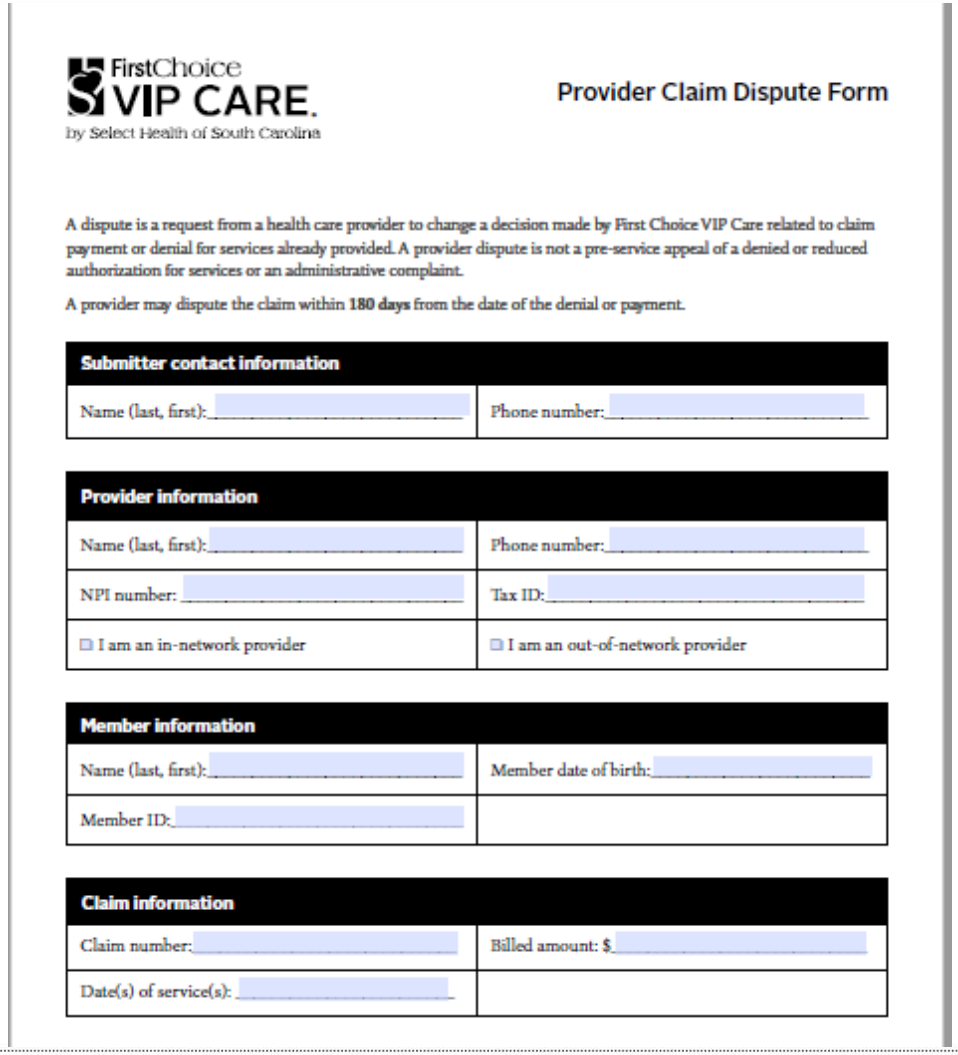
Claims — Provider Claim Inquiry/Dispute

If a First Choice VIP Care provider has an inquiry, such as claim status, or a dispute regarding the way a claim was processed or adjudicated, the provider should do one of the following:

- Call Provider Service to make a verbal inquiry and/or dispute.
- Complete the Claim Dispute form which is located on the AmeriHealth Caritas VIP Care Plan website under Provider > Resources > Claims and Billing.
- Send a written request instead of the Claim Dispute form, including the following:
  - ✓ Submitter contact information (name, phone number).
  - ✓ Provider information (name, phone number, NPI number, Tax ID number).
  - ✓ Member information (name, DOB, member ID number).
  - ✓ Claim information (claim number, DOS, billed amount).
  - ✓ Reason for dispute.
  - ✓ Any documentation which supports your position that the plan's reimbursement is not correct.
- Disputes should be submitted within 180 days of the initial remittance advice to:

  First Choice VIP Care
  Claims Processing Department
  P.O. Box 7182
  London, KY 40742-7182

Claims — Provider Claim Inquiry/Disputes Form



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by Select Health of South Carolina

Provider Claim Dispute Form

A dispute is a request from a health care provider to change a decision made by First Choice VIP Care related to claim payment or denial for services already provided. A provider dispute is not a pre-service appeal of a denied or reduced authorization for services or an administrative complaint.

A provider may dispute the claim within **180 days** from the date of the denial or payment.

Submitter contact information	
Name (last, first):	Phone number:

Provider information	
Name (last, first):	Phone number:
NPI number:	Tax ID:
☐ I am an in-network provider	☐ I am an out-of-network provider

Member information	
Name (last, first):	Member date of birth:
Member ID:	

Claim information	
Claim number:	Billed amount: $
Date(s) of service(s):	

Payment — Balance Billing Requirements

- Per Section 1902(n)(3)(B) of the Social Security Act, as modified by 4714 of the Balanced Budget Act of 1997, Medicare providers cannot collect Medicare Parts A and B deductibles, coinsurance, or copays from members enrolled as a Qualified Medicare Beneficiary (QMB).
- First Choice VIP Care **members** will have no out-of-pocket responsibility for all Medicare services. Some traditional Medicaid services may require copayments, as determined by the state. Providers must accept payment for these services as payment in full and ***may not balance-bill*** the First Choice VIP Care member.
- First Choice VIP Care **providers** will have deductibles and coinsurance applied to payments.
- In the event of a balance from deductible or coinsurance, providers should submit appropriate claims to **South Carolina Healthy Connections Medicaid**.
- Providers may also not bill for contractual disallowances and non-covered services (unless a prior written agreement was signed by the member and provider).
- All providers are encouraged to use the claims inquiry/dispute process to resolve any outstanding claims payment issues.

Report Suspected Fraud, Waste or Abuse

Providers who suspect that a First Choice VIP Care provider, employee or member is committing fraud, waste or abuse should notify the First Choice VIP Care Special Investigative Unit as follows:

By phone: 1-866-833-9718
By U.S. mail:

First Choice VIP Care Special Investigative Unit
200 Stevens Drive
Philadelphia, PA 19113

Reports may also be sent directly to the U.S. Department of Health and Human Services one of the following ways:

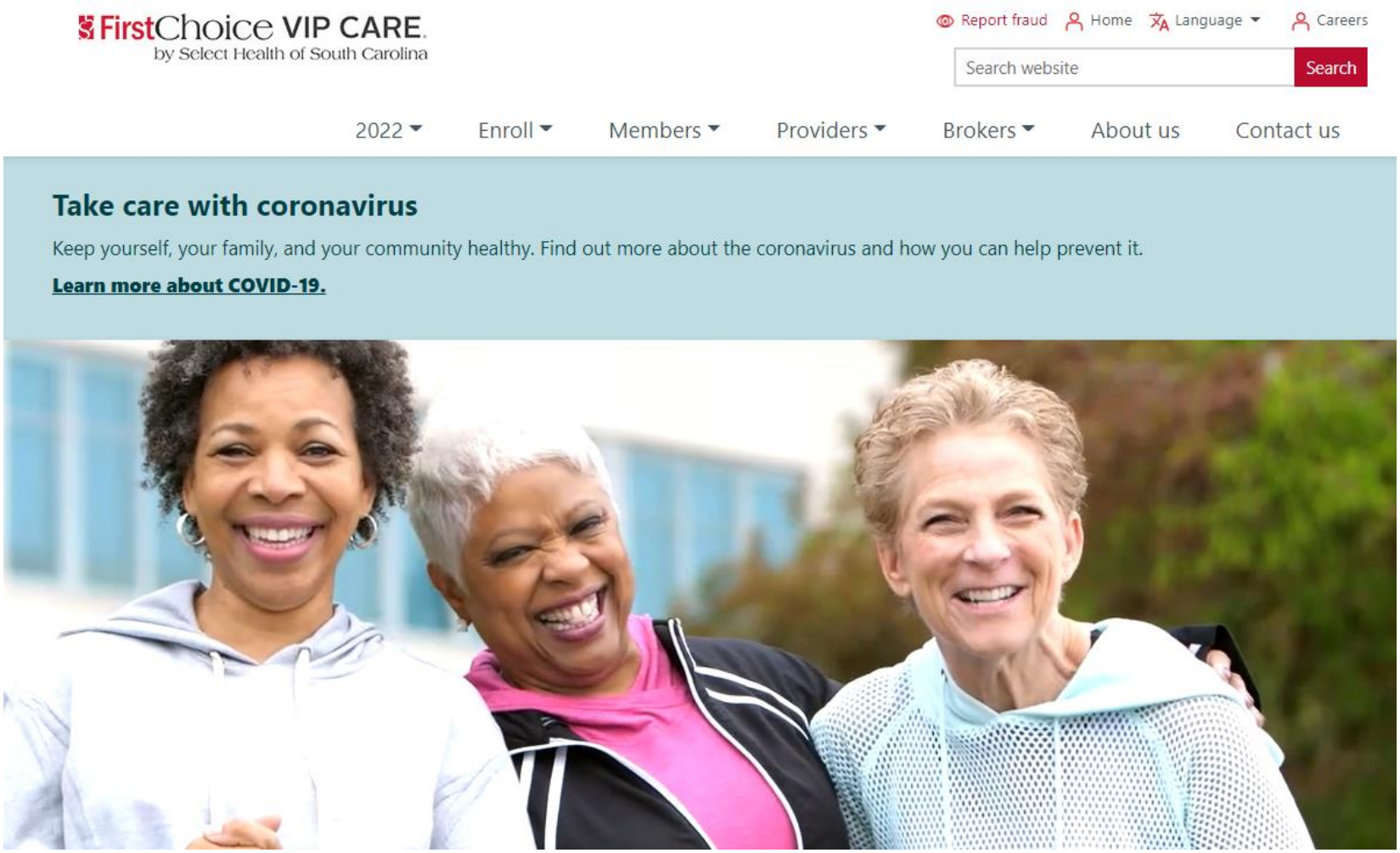
By calling 1-877-7SAFERX (772-3379)
Online at hhstips@oig.hhs.gov
Information may be left anonymously.

Provider Resources

A Quick Guide on Provider Resources

FirstChoice VIP CARE
by Select Health of South Carolina

First Choice VIP Care Website



Website Highlights

Available resources on the website:

- Provider Manual.
- Prior Authorizations Look-up Tool.
- Searchable Provider Directory.
- Searchable Drug Formulary.
- Training Modules.
- Provider Communications.
- Forms.
- Provider Reference Guide.
- Link to NaviNet.
- And much more…

www.firstchoicevipcare.com

Provider Manual Highlights

- First Choice VIP Care Overview
- Provider and Network Information
- Provision of Services
- Model of Care and Integrated Care Management
- Utilization Management
- Grievances, Appeals, and Fair Hearings
- Quality Assurance and Performance Improvement Program
- Cultural Competency Program and Requirements
- Behavioral Health Care

The complete Provider Manual can be found on the First Choice VIP Care website at www.firstchoicevipcare.com under the Provider Resources link.

NaviNet Provider Portal Highlights

NaviNet is America's leading healthcare provider portal connecting over 40 health plans and 60% of the nation's physicians. NaviNet is not only used by First Choice VIP Care, but also payers like Cigna and Aetna.

Through NaviNet providers can:

- Check claim status.
- Print copies of remittances.
- Check member eligibility.
- Enter authorization requests.
- Generate reports.

To sign up for NaviNet go to the link on our website or https://navinet.secure.force.com/.

First Choice VIP Care
Reaching for 5 Stars

Quality Improvement Measures Identified by CMS Stars Program

FirstChoice VIP CARE
by Select Health of South Carolina

What is the Star Initiative?

- In 2007 The Centers for Medicare and Medicaid Services (CMS) developed a quality and financial incentive program that rewards Medicare Advantage plans.
- The financial incentives must be used to improve members benefits and or reduce costs for members enrolled in the health plan.
- Star measures assess quality healthcare and plan responsiveness.
- Helps beneficiaries to easily compare plan performance and quality for Medicare Advantage plans.

How is the Star measure determined?

- There are 38 Star measures for Medicare Advantage plans (Part C) with prescription drug coverage (Part D).

- Each measure is rated on a scale of 1 to 5, with a 5 being the highest score.
- Some measures are weighted more heavily than others.
- A combined score gives the **Overall Star Measure** for the plan. More stars indicate better quality and performance for the types of services each plan offers:

  5-star rating: Excellent

  4-star rating: Above Average

  3-star rating: Average

  2-star rating: Below Average

  1-star rating: Poor

Increased Benefits

Becoming a Five-Star plan is an incredibly prestigious achievement that only select health plans are awarded annually. Health plans that earn at least four stars qualify for federal bonus payments, which by law, must be returned to the beneficiary in the form of additional or enhanced benefits, such as reduced premiums or cost-sharing (e.g., copayments) or expanded coverage.

Increased Benefits

A higher Star ratings can benefit providers and members.

Benefits for providers may include:

- Greater focus on preventive care and early detection of disease.
- Better performance in provider incentive programs and shared savings programs.
- Potential for increased patient base (Five-Star Rating plans are granted a special enrollment period, allowing Medicare beneficiaries to enroll throughout the year).
- Improved relations with your patients and AmeriHealth Caritas VIP Care.

Benefits for members may include:

- Greater focus on preventive services for early detection of disease
- Greater focus on access to and quality of care
- Increased level of customer service
- Improved care coordination and health outcomes

What is measured (Part C)?

For plans covering **health services**, the overall rating is based on the quality of many medical/health care services that fall into 5 categories:

- **Staying healthy: screening tests and vaccines.** Includes whether members got various screening tests, vaccines, and other check-ups to help them stay healthy.
- **Managing chronic (long-term) conditions**: Includes how often members with certain conditions got recommended tests and treatments to help manage their condition.
- **Member experience with the health plan**: Includes member ratings of the plan.
- **Member complaints and changes in the health plan's performance:** Includes how often Medicare found problems with the plan and how often members had problems with the plan. Includes how much the plan's performance has improved (if at all) over time.
- **Health plan customer service**: Includes how well the plan handles member appeals.

What is measured (Part D)?

For plans covering **drug services**, the overall rating is based on the quality of prescription-related services that fall into 4 categories:

- **Drug plan customer service:** Includes how well the plan handles member appeals.
- **Member complaints and changes in the drug plan's performance**: Includes how often Medicare found problems with the plan and how often members had problems with the plan. Includes how much the plan's performance has improved (if at all) over time.
- **Member experience with plan's drug services:** Includes member ratings of the plan.
- **Drug safety and accuracy of drug pricing**: Includes how accurate the plan's pricing information is and how often members with certain medical conditions are prescribed drugs in a way that is safer and clinically recommended for their condition.

Where do the scores come from?

Many data sources are used to calculate the ratings for each measure:

- **HEDIS =** Health Care Effectiveness Data Information Set
- **HOS** = Health Outcomes Survey (member)
- **CAHPS** = Consumer Assessment of HealthCare Providers and Systems (member)
- **CMS Data Sources** = Eligibility, “Secret Shoppers” surveys / Notices
- **IRE** = Independent Review Entity
- **CTM** = Complaint Tracking Module
- **PDE** = Prescription Drug Event data
- **Plan Reporting**

What HEDIS Measures are in the Star Rating?

Star Measures	Source	Weight
Diabetes Care - Blood Sugar Controlled	HEDIS	3
Breast Cancer Screening	HEDIS	1
Colorectal Cancer Screening	HEDIS	1
Osteoporosis Management in Women who had a Fracture	HEDIS	1
Diabetes Care - Eye Exam	HEDIS	1
Diabetes Care - Kidney Disease Monitoring	HEDIS	1
Statin Therapy for Patients with Cardiovascular Disease	HEDIS	1
Care for Older Adults – Medication Review	HEDIS	1
Care for Older Adults – Pain Assessment	HEDIS	1
Controlling Blood Pressure	HEDIS	1
Medication Reconciliation Post-Discharge	HEDIS	1

What CAHPS Measures are in the Star Rating?

Star Measures	Source	Weight
Getting Needed Care	CAHPS	4
Getting Appointments and Care Quickly	CAHPS	4
Customer Service	CAHPS	4
Rating of Health Care Quality	CAHPS	4
Rating of Health Plan	CAHPS	4
Rating of Drug Plan	CHAPS	4
Getting Needed Prescription Drugs	CHAPS	4
Care Coordination	CAHPS	4
Annual Flu Vaccine	CAHPS	1

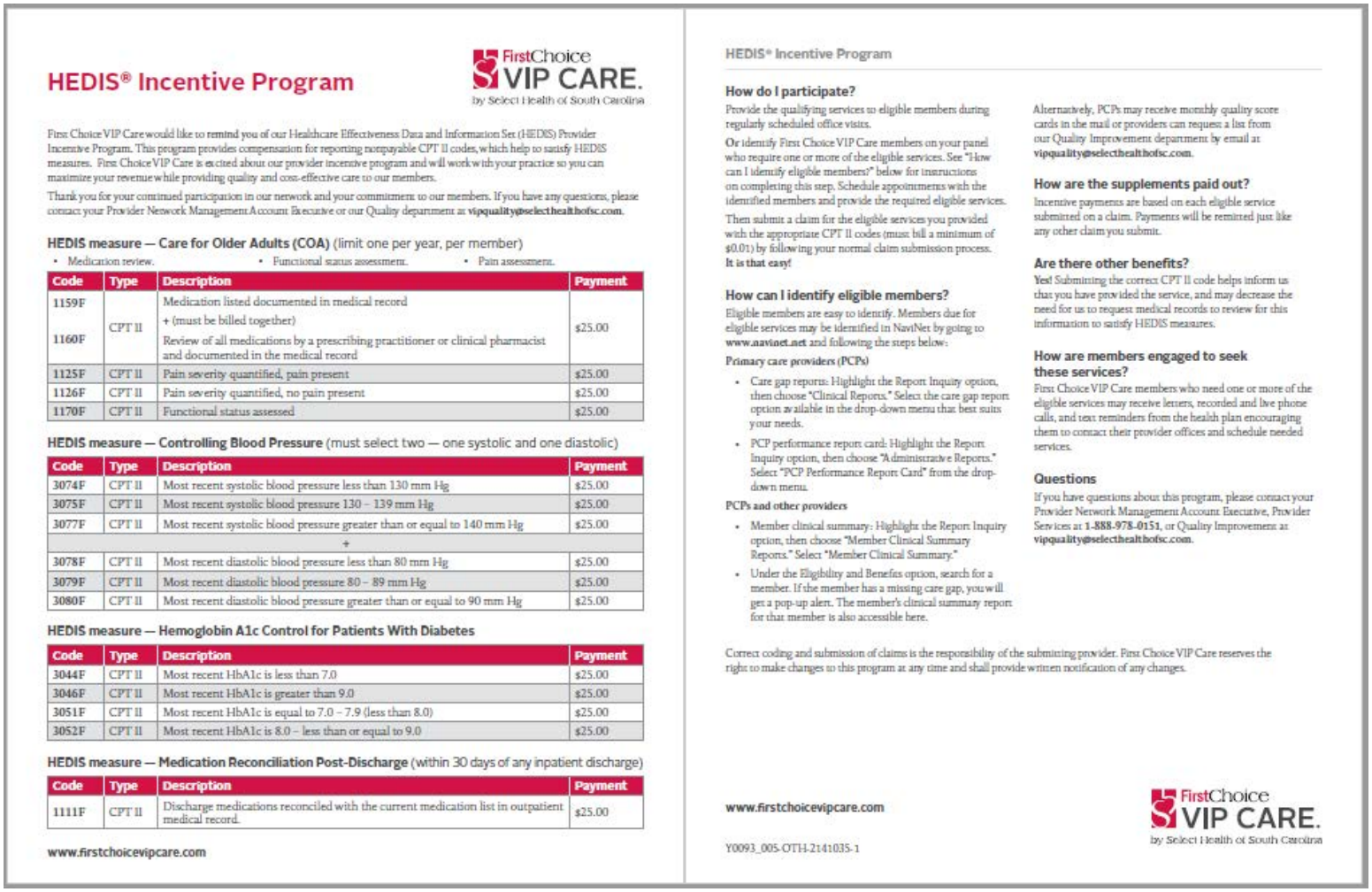
What Other Measures are in the Star Rating?

Star Measures	Source	Weight
Health Plan Quality Improvement	STARS	5
Drug Plan Quality Improvement	STARS	5
Complaints about the Health Plan	CTM	4
Complaints about the Drug Plan	CTM	4
Members Choosing to Leave the Plan	MBDSS	4
Plan Makes Timely Decisions about Appeals	IRE	4
Reviewing Appeals Decisions	IRE	4
Call Center - Foreign Language Interpreter and TTY Availability	Call Center Monitoring	4
Call Center - Foreign Language Interpreter and TTY Availability (drug plan)	Call Center Monitoring	4
Medication Adherence for Diabetes Medications	Prescription Drug Event Data	3
Medication Adherence for Hypertension (RAS antagonists)	Prescription Drug Event Data	3
Medication Adherence for Cholesterol (Statins)	Prescription Drug Event Data	3
Statin Use in Persons with Diabetes (SUPD)	Prescription Drug Event Data	3
Monitoring Physical Activity	HEDIS - HOS	1
Special Needs Plan (SNP) Care Management	Plan Reporting	1
Reducing the Risk of Falling	HEDIS - HOS	1
Improving Bladder Control	HEDIS - HOS	1
MPF Price Accuracy	MPF Pricing Files	1
MTM Program Completion Rate for CMR	Prescription Drug Event Data	1

Quality Metrics

FirstChoice VIP CARE
by Select Health of South Carolina

HEDIS Incentive Program



HEDIS® Incentive Program

FirstChoice VIP CARE. by Select Health of South Carolina

First Choice VIP Care would like to remind you of our Healthcare Effectiveness Data and Information Set (HEDIS) Provider Incentive Program. This program provides compensation for reporting nonpayable CPT II codes, which help to satisfy HEDIS measures. First Choice VIP Care is excited about our provider incentive program and will work with your practice so you can maximize your revenue while providing quality and cost-effective care to our members.

Thank you for your continued participation in our network and your commitment to our members. If you have any questions, please contact your Provider Network Management Account Executive or our Quality department at **vipquality@selecthealthofsc.com**.

HEDIS measure — Care for Older Adults (COA) (limit one per year, per member)

- Medication review.
- Functional status assessment.
- Pain assessment.

Code	Type	Description	Payment
1159F	CPT II	Medication listed documented in medical record + (must be billed together) Review of all medications by a prescribing practitioner or clinical pharmacist and documented in the medical record	$25.00
1160F			
1125F	CPT II	Pain severity quantified, pain present	$25.00
1126F	CPT II	Pain severity quantified, no pain present	$25.00
1170F	CPT II	Functional status assessed	$25.00

HEDIS measure — Controlling Blood Pressure (must select two — one systolic and one diastolic)

Code	Type	Description	Payment
3074F	CPT II	Most recent systolic blood pressure less than 130 mm Hg	$25.00
3075F	CPT II	Most recent systolic blood pressure 130 – 139 mm Hg	$25.00
3077F	CPT II	Most recent systolic blood pressure greater than or equal to 140 mm Hg	$25.00
		+	
3078F	CPT II	Most recent diastolic blood pressure less than 80 mm Hg	$25.00
3079F	CPT II	Most recent diastolic blood pressure 80 – 89 mm Hg	$25.00
3080F	CPT II	Most recent diastolic blood pressure greater than or equal to 90 mm Hg	$25.00

HEDIS measure — Hemoglobin A1c Control for Patients With Diabetes

Code	Type	Description	Payment
3044F	CPT II	Most recent HbA1c is less than 7.0	$25.00
3046F	CPT II	Most recent HbA1c is greater than 9.0	$25.00
3051F	CPT II	Most recent HbA1c is equal to 7.0 – 7.9 (less than 8.0)	$25.00
3052F	CPT II	Most recent HbA1c is 8.0 – less than or equal to 9.0	$25.00

HEDIS measure — Medication Reconciliation Post-Discharge (within 30 days of any inpatient discharge)

Code	Type	Description	Payment
1111F	CPT II	Discharge medications reconciled with the current medication list in outpatient medical record.	$25.00

www.firstchoicevipcare.com

How do I participate?

Provide the qualifying services to eligible members during regularly scheduled office visits.

Or identify First Choice VIP Care members on your panel who require one or more of the eligible services. See "How can I identify eligible members?" below for instructions on completing this step. Schedule appointments with the identified members and provide the required eligible services.

Then submit a claim for the eligible services you provided with the appropriate CPT II codes (must bill a minimum of $0.01) by following your normal claim submission process. **It is that easy!**

How can I identify eligible members?

Eligible members are easy to identify. Members due for eligible services may be identified in NaviNet by going to **www.navinet.net** and following the steps below:

Primary care providers (PCPs)

- Care gap reports: Highlight the Report Inquiry option, then choose "Clinical Reports." Select the care gap report option available in the drop-down menu that best suits your needs.
- PCP performance report card: Highlight the Report Inquiry option, then choose "Administrative Reports." Select "PCP Performance Report Card" from the drop-down menu.

PCPs and other providers

- Member clinical summary: Highlight the Report Inquiry option, then choose "Member Clinical Summary Reports." Select "Member Clinical Summary."
- Under the Eligibility and Benefits option, search for a member. If the member has a missing care gap, you will get a pop-up alert. The member's clinical summary report for that member is also accessible here.

Alternatively, PCPs may receive monthly quality score cards in the mail or providers can request a list from our Quality Improvement department by email at **vipquality@selecthealthofsc.com**.

How are the supplements paid out?

Incentive payments are based on each eligible service submitted on a claim. Payments will be remitted just like any other claim you submit.

Are there other benefits?

Yes! Submitting the correct CPT II code helps inform us that you have provided the service, and may decrease the need for us to request medical records to review for this information to satisfy HEDIS measures.

How are members engaged to seek these services?

First Choice VIP Care members who need one or more of the eligible services may receive letters, recorded and live phone calls, and text reminders from the health plan encouraging them to contact their provider offices and schedule needed services.

Questions

If you have questions about this program, please contact your Provider Network Management Account Executive, Provider Services at **1-888-978-0151**, or Quality Improvement at **vipquality@selecthealthofsc.com**.

Correct coding and submission of claims is the responsibility of the submitting provider. First Choice VIP Care reserves the right to make changes to this program at any time and shall provide written notification of any changes.

www.firstchoicevipcare.com

FirstChoice VIP CARE. by Select Health of South Carolina

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Quality Metrics – Medicare Stars Rating

As a Medicare Advantage (MA) plan, CMS measures the quality of the healthcare our members receive and how responsive our plan is through the Star Rating program. For the Stars rating our quality is measured through various sources:

1. **Healthcare Effectiveness Data and Information Set (HEDIS)** – A comprehensive set of standardized performance measures designed to provide purchasers and consumers with the information they need for reliable comparison of health plan performance.

2. **Consumer Assessment of Healthcare Provider and Systems (CAHPS)** – This CMS survey asks patients (or in some cases their families) about their experiences with, and ratings of, their health care providers and plans, including hospitals, home health care agencies, doctors, and health and drug plans, among others.

3. **Health Outcomes Survey (HOS)** – This CMS survey is a patient-reported outcomes measure used in Medicare managed care. The goal of the Medicare HOS is to gather valid, reliable, and clinically meaningful health status data from the MA program to use in quality improvement activities, pay for performance, program oversight, public reporting, and to improve health.

4. Other Stars specific measurements.

Care for Older Adults - HEDIS

Plan Interventions:

Care for Older Adults (COA) includes a group of assessments intended to serve as additional preventive screenings for adults age 66 and over.

Advance care planning	Functional assessment
Pain assessment	Medication review/list

First Choice VIP Care is able to assist providers in completing these assessments:

- ✓ Care management is contacting members to complete COA assessments including – pain, advanced directives and functional status.
- ✓ Pharmacy department is conducting care for older adults medication reviews.
- ✓ Completed COA assessment forms are sent to members PCP's and must be filed in the member records in order to satisfy the HEDIS requirement.

Providers may access blank COA forms for their use on our website under Provider> Resources. A good time to complete these assessments is during the Annual Wellness Visit.

Care for Older Adults - HEDIS

Provider Guidelines - Providers may also satisfy the COA requirement by completing the assessment form or documenting the assessment on a claim using the following codes :

Care for Older Adults (COA) • Advance Care Planning • Functional Status Assessment • Pain Assessment • Medication Review	Members 66 years and older who had each of the following during the measurement year: **Advance care planning** - Evidence of advance care planning during the measurement year (i.e. advance directive, actionable medical orders, living will, surrogate decision maker). **Functional status assessment** - At least one functional status assessment during the measurement year (i.e. ADL, IADL, result of assessment using a standardized functional assessment tool,). **Pain assessment** – Documentation of at least one pain assessment during the measurement year. **Medication review** – any of the following: • Both of the following on the same date of service during the measurement year: o At least one medication review conducted by a prescribing practitioner or clinical pharmacist. o The presence of a medication list in the medical record.	**CPT/HCPCS/ICD10CM Codes:** **Advance Care Planning:** 99483, 99497, 1123F, 1124F, 1157F, 1158F, S0257, Z66 **Functional Status Assessment:** 99483, 1170F, G0438, G0439 **Pain Assessment:** 1125F, 1126F **Medication Review:** 90863, 99483, 99605, 99606, 1160F **Medication List:** 1159F, G8427 **Transitional Care Management:** 99495, 99496

Influenza Vaccine – Consumer Assessment of Healthcare Provider and Systems Survey (CAHPS)

Plan Interventions:

Member incentives, reminder postcards, automated call and text blasts, Care Management Team calls, and partner with providers for flu clinics.

Provider Guidelines:

We ask for your help, as a provider, in helping to ensure your patients receive influenza vaccines. Your role in this effort is critical to help avert the considerable toll that influenza takes on the public's health each year.

Per the CDC, although people 65 years old and older can get any injectable influenza vaccine, there are two vaccines specifically designed for people 65 years old and older:

- The "high-dose vaccine" is designed specifically for people 65 years old and older and contains four times the amount of antigen as the regular flu shot. It is associated with a stronger immune response following vaccination (higher antibody production).
- The adjuvanted flu vaccine, Fluad™, is made with MF59 adjuvant, which is designed to help create a stronger immune response to vaccination.

Influenza Vaccine - CAHPS

Please be reminded that participating providers will be reimbursed 100% of the Medicare allowable for the influenza vaccines noted below, along with the administration code G0008 for your Medicare patients in our plan:

Please reference the CMS Seasonal Influenza Vaccine Pricing website for currently covered vaccines and reimbursement rates:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing

Diabetes Care - HEDIS

The Diabetes HEDIS measure is now comprised of four individual measures and can be reported using CPT or CPT II codes:

1. Hemoglobin A1c Control for Patients with Diabetes (HBD)
2. Kidney Health Evaluation for Patients with Diabetes (KED)
3. Eye Exam for Patients with Diabetes (EED)
4. Blood Pressure Control for Patients with Diabetes (BPD)

Plan Intervention:

Diabetic members are being offered in-home diabetic testing including HbA1C, urine and eye imaging when approved by treating provider. Sending letters to providers and members when tests are missing. Offer HbA1c testing at member events.

Diabetes Care - Hemoglobin A1c Control for Patients with Diabetes (HBD) - HEDIS

Measure Name	Measure Description	Coding Tips/Notes
Hemoglobin A1c Control for Patients with Diabetes (HBD)* **Formerly the Comprehensive Diabetes Care (CDC)-HgbA1c Testing & HgbA1c Result: Control vs. Poor Control*	Members 18 – 75 years of age with diabetes (type 1 or type 2) whose hemoglobin A1c (HbA1c) was the following in the Measurement Year (MY): • HbA1c control (<8.0%) • HbA1c poor control (>9%) At a minimum, the documentation in the medical record must include a note indicating the date when the **most recent** HbA1c test was performed in the MY and the result or findings. ***A lower rate in Poor Control (>9%) indicates better performance.*** *Members who meet any of the following criteria are excluded from the measure:* • *In hospice or using hospice services any time in the MY.* • 66 years of age and older with frailty **and** advanced illness during the MY. • *Receiving palliative care any time in the MY.* • *Members who did not have a diagnosis of diabetes in the MY or the year prior AND who had a diagnosis of Diagnosis of Polycystic ovarian syndrome, gestational diabetes, or steroid induced diabetes during the MY or the year prior* *Non-compliant members may be excluded from the measure with documentation of any of the following:* • *Deceased in the MY.*	**CPT Codes:** • ***HbA1c Testing: 83036, 83037*** • ***HbA1c Less than 7.0: 3044F*** • ***HbA1c greater than or equal to 7.0 and less than 8.0: 3051F*** • ***HbA1c greater than or equal to 8.0 and less than or equal to 9.0: 3052F*** • ***HbA1c greater than 9.0: 3046F***

Diabetes Care - Eye Exam for Patients with Diabetes (EED) - HEDIS

Eye Exam for Patients with Diabetes (EED)* **Formerly the Comprehensive Diabetes Care (CDC)-Eye Exam*	Members 18–75 years of age with diabetes (type 1 and type 2) who had a retinal eye exam during the Measurement Year (MY), or an exam with a negative result in the year prior to the MY or documentation of bilateral eye enucleation any time prior to 12/31 of the MY. *Members who meet any of the following criteria are excluded from the measure:* • *In hospice or using hospice services any time in the MY.* • 66 years of age and older with frailty **and** advanced illness during the MY. • *Receiving palliative care any time in the MY.* • *Members who did not have a diagnosis of diabetes in the MY or the year prior AND who had a diagnosis of Diagnosis of Polycystic ovarian syndrome, gestational diabetes, or steroid induced diabetes during the MY or the year prior.* *Non-compliant members may be excluded from the measure with documentation of any of the following:* • *Deceased in the MY.* ** Blindness is not an exclusion for a diabetic eye exam**	**Diabetic Retinal Screening Eye Care Professional Only Exam CPT/HCPCS/CPT-CAT-II Codes:** 67028, 67030, 67031, 67036, 67039, 67040, 67041, 67042, 67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92201, 92202, 92225,92226, 92227, 92228, 92230, 92235, 92240, 92250, 92260, 99203, 99204, 99205, 99213. 99214, 99215, 99242. 99243, 99244, 99245, S0620, S0621, S3000 **Primary care Physician Positive exam:** 2022F, 2024F, 2026F **Primary care Physician Negative exam:** 3072F, 2023F, 2025F, 2033F

Diabetes Care - Kidney Evaluation for Patients With Diabetes (KED) - HEDIS

Kidney Evaluation for Patients With Diabetes (KED)* **Formerly the Comprehensive Diabetes Care-Monitoring for Nephropathy*	The percentage of member 18 – 85 with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ration (uACR), during the Measurement Year (MY). *Members who meet any of the following criteria are excluded from the measure:* • *In hospice or using hospice services any time in the MY.* • 66 years of age and older with frailty **and** advanced illness during the MY. • *81 years of age and older with frailty during the MY.* • *Receiving palliative care any time in the MY.* • *Evidence of End-stage Renal Disease (ESRD) any time during the member's history through 12/31 of the MY.* • *Evidence of ESRD or dialysis any time during the member's history through 12/31 of the MY.* *Non-compliant members may be excluded from the measure with documentation of any of the following:* • *No diagnosis of Diabetes in any setting during the MY or the year prior and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes during the MY or the year prior.* • *Deceased in the MY*	Service dates of Quantitative Urine Albumin Lab Test and Urine Creatinine Lab Test must be four or less days apart. **All three are required:** 1. **Estimated Glomerular Filtration Rate Lab Test - CPT:** 80047, 80048, 80050, 80053, 80069, 82565 2. **Quantitative Urine Albumin Lab Test - CPT:** 82043 3. **Urine Creatinine Lab Test - CPT:** 82570

Controlling Blood Pressure - HEDIS

Plan Interventions:

Our plan is assessed on how well our providers are controlling their patients' (our members') blood pressure through the HEDIS measure, Controlling High Blood Pressure. This measure determines the percentage of patients 60 to 85 years of age who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled during the measurement year, based on the following criteria:

- Patients 60 to 85 years of age with a diagnosis of diabetes whose BP was less than 140/90 mm Hg.
- Patients 60 to 85 years of age without a diagnosis of diabetes whose BP was less than 150/90 mm Hg.

Only about half of people with high blood pressure have it under control, which means they are at higher risk for heart disease and stroke. Another 1 in 5 adults don't even know they have high blood pressure.

As a plan we offer member incentives, education and a blood pressure cuff benefit. Review medications for compliance and educate members on 90-day refills. Offer to take blood pressure at member events.

Diabetes Care - Blood Pressure Control for Patients with Diabetes (BPD) + Controlling High Blood Pressure (CBP) - HEDIS

Plan Interventions:

Our plan is assessed on how well our providers are controlling their patients' (our members') blood pressure through the both of these HEDIS measures. These measures determine the percentage of patients 18 to 85 years of age who had a diagnosis of hypertension and/or diabetes and whose blood pressure (BP) was adequately controlled during the measurement year, based on the following criteria:

- Patients 18 to 85 years of age with or without a diagnosis of diabetes whose BP was less than 140/90 mm Hg.

Only about half of people with high blood pressure have it under control, which means they are at higher risk for heart disease and stroke. Another 1 in 5 adults don't even know they have high blood pressure.

As a plan we offer member incentives, education and a blood pressure cuff benefit. Review medications for compliance and educate members on 90-day refills. Offer to take blood pressure at member events.

Blood Pressure Control for Patients with Diabetes (BPD) + Controlling High Blood Pressure (CBP) - HEDIS

Provider Guidelines:

Before providers can begin to control high blood pressure, it is important to first obtain an accurate blood pressure. Even small inaccuracies of 5 – 10 mm Hg can have considerable consequences. Here are some factors that can affect the accuracy of a blood pressure measures and the magnitude of the discrepancies:

Factor	Magnitude of systolic/diastolic blood pressure discrepancy (mm Hg)
Talking or active listening	10/10
Distended bladder	15/10
Cuff over clothing	5–50/
Cuff too small	10/2–8
Smoking within 30 minutes of measurement	6–20/
Paralyzed arm	2–5/
Back unsupported	6–10/
Arm unsupported, sitting	1–7/5–11
Arm unsupported, standing	6–8/

Blood Pressure Control for Patients with Diabetes (BPD) + Controlling High Blood Pressure (CBP) - HEDIS

The blood pressure measures can be reported using CPT II codes. Below are the CPT II codes that correspond to particular systolic and diastolic blood pressure measurements (select one of each).

Code	Type	Measure	Description
3074F	CPT II	Controlling Blood Pressure	Most recent systolic blood pressure less than 130 mm Hg
3075F	CPT II	Controlling Blood Pressure	Most recent systolic blood pressure 130 – 139 mm Hg
3077F	CPT II	Controlling Blood Pressure	Most recent systolic blood pressure greater than or equal to 140 mm Hg
3078F	CPT II	Controlling Blood Pressure	Most recent diastolic blood pressure less than 80 mm Hg
3079F	CPT II	Controlling Blood Pressure	Most recent diastolic blood pressure 80-89 mm Hg
3080F	CPT II	Controlling Blood Pressure	Most recent diastolic blood pressure greater than or equal to 90 mm Hg

Colorectal Cancer Screening - HEDIS

Plan Intervention:

Working with lab vendors to offer members in-home screening kits.

Provider Guidelines:

Colorectal Cancer Screening (COL)	Members 50-75 years of age who had appropriate screening for colorectal cancer, which includes: • Fecal occult blood test (FOBT) during the measurement year • Flexible sigmoidoscopy or CT Colonography during the measurement year or four years prior to the measurement year • Colonoscopy during the measurement year or nine years prior to the measurement year • FIT-DNA test during the measurement year or two years prior to the measurement year. **Note:** Digital rectal exams (DRE) and FOBT tests performed in an office setting or performed on a sample collected via DRE do not meet measure specifications.	**Flexible Sigmoidoscopy CPT/HCPCS Codes:** 45330, 45331, 45332, 45333, 45334,45335, 45337, 45338, 45339, 45340, 45341, 45342, 45345, 45346, 45347, 45349, 45350, G0104 **Colonoscopy CPT/HCPCS Codes:** 44388, 44389, 44390, 44391, 44392, 44393, 44394, 44397, 44401, 44402, 44403, 44404, 44405, 44406, 44407, 44408, 45355, 45378, 45379, 45380, 45381, 45382, 45383, 45384, 45385, 45386, 45387, 45388, 45389, 45390, 45391, 45392, 45393, 45398, G0105, G0121 **CT Colonography CPT Codes:** 74261, 74262, 74263 **FIT-DNA CPT/HCPCS Codes:** 81528, G0464 **FOBT Lab Test CPT/HCPCS Codes:** 82270, 82274, G0328

Breast Cancer Screening - HEDIS

Plan Intervention:

Receive orders for non-compliant members and do member outreach campaigns to assist members scheduling mammograms. Send out reminder postcards.

Provider Guidelines:

Breast Cancer Screening (BCS)	Women 50-74 years of age who had a mammogram to screen for breast cancer during the measurement year or the two years prior to the measurement year. • Based on claim for mammography only. Biopsies, breast ultrasounds and MRIs are not included. • Excludes women with documented mastectomy.	**Mammography CPT/HCPCS Codes:** 77055, 77056, 77057, 77061, 77062, 77063, 77065, 77066, 77067, G0202, G0204, G0206

Osteoporosis Management in Women Who Had a Fracture - HEDIS

Plan Intervention:

Letters to providers on members who are high-risk for falls. Encouraging Bone Mineral Density testing and/or medication prior to the 6 month post fracture date - going out to new members monthly. Meet with Pharmacy to review/discuss each member in the measure and outreach to non-compliant members.

Provider Guidelines:

Osteoporosis Management in Women Who Had a Fracture (OMW)	Women 67-85 years of age who suffered a fracture and who had either a bone or mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture. (Fractures of finger, toe, face and skull are not included in this measure) *Members who meet any of the following criteria are excluded from the measure:* • *In hospice or using hospice services in the measurement year (MY).* • *Receiving palliative care any time in the MY.* • *Deceased in the MY.*	HEDIS rates are based on pharmacy (medication) claims or Bone Mineral Density Tests. **Medications:** • Abaloparatide • Alendronate • Alendronate-cholecalciferol • Denosumab • Ibandronate • Raloxifene • Risedronate • Romosozumab • Teriparatide • Zoledronic acid **Bone Mineral Density Tests CPT Codes:** 76977, 77078, 77080, 77081, 77085, 77086

Transition of Care (TRC) - HEDIS

CMS understands the importance of providing transition of care services when a member is discharged from a hospital. This new measure looks at the members 18 years of age and older who had an inpatient discharge for which each of the following occurred:

1. **Notification of Inpatient Admission** – Documentation must include evidence of receipt of notification of inpatient admission on the day of admission through the 2 days following admission.
2. **Receipt of Discharge Information** – Documentation must include evidence of receipt of discharge information on the day of discharge through the 2 days following discharge.
3. **Patient Engagement after Inpatient Discharge** – Documentation must include evidence of patient engagement within 30 days following discharge.
4. **Medication Reconciliation Post-Discharge** – Documentation in the outpatient medical record must include evidence of medication reconciliation and the date it was performed by a prescribing practitioner (including physician assistant), clinical pharmacist or registered nurse, as documented on the date of discharge through 30 days after discharge (31 total days).

Transition of Care (TRC) - HEDIS

Patient Engagement Indicators:

- **Outpatient - CPT:** 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, 99455, 99456, 99483
- **Outpatient - HCPCS:** G0402, G0438, G0439, G0463, T1015
- **Telephone Visits - CPT:** 98966, 98967, 98968, 99441, 99442, 99443
- **Transitional Care Management Services - CPT:** 99495, 99496
- **Online Assessments - CPT:** 98969, 98970, 98971, 98972, 98972, 99421, 99422, 99423, 99444, 99457, 99458
- **Online Assessments - HCPCS:** G0071, G2010, G2012, G2061, G2062, G2063

Medication Reconciliation Post-Discharge Indicators:

- **Medication Reconciliation Encounter - CPT:** 99483, 99495, 99496
- **Medication Reconciliation Intervention - CPT-CAT-II:** 1111F

The Notification of Inpatient Admission and Receipt of Discharge Information has no administrative reporting option. They are based on medical record review only.

Medicare Stars Medication Adherence Measures - Non-HEDIS

Medication Adherence for Cholesterol – statins	Percentage of plan members with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80 percent or more of the time they are supposed to be taking the medication during the measurement year.	**Includes Cholesterol (Statin) Medications** • Atorvastatin • Fluvastatin • Lovastatin • Pitavastatin • Pravastatin • Rosuvastatin • Simvastatin
Statin Use in Persons With Diabetes	Percentage of plan members with diabetes who take the most effective cholesterol-lowering (statin) drugs. Members who have a prescription for at least two diabetes medication fills and who received a statin medication fill during the measurement year.	**Includes Cholesterol (Statin) Medications** • Atorvastatin • Fluvastatin • Lovastatin • Pitavastatin • Pravastatin • Rosuvastatin • Simvastatin

Medicare Stars Medication Adherence Measures - Non-HEDIS - continued

Medication Adherence for Diabetes Medication	Percentage of plan members with a prescription for diabetes medication who fill their prescription often enough to cover 80 percent or more of the time they are supposed to be taking the medication during the measurement year. *Members/patients who take insulin are not included.*	**Includes Diabetes Medication Types:** • Biguanides • Sulfonylureas • Thiazolidinediones • Dipeptidyl peptidase-IV (DPP-IV) inhibitor • Incretin Mimetics • Meglitinides • Sodium glucose cotransporter 2 (SGLT2) inhibitors
Medication Adherence for Hypertension (RAS antagonists)	Percentage of plan members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80 percent or more of the time they are supposed to be taking the medication during the measurement year.	**Includes Hypertension (Renin Angiotensin System (RAS) Antagonist) Medication Types:** • Angiotensin-converting enzyme (ACE) inhibitors • Angiotensin receptor blockers (ARB) • Direct Renin Inhibitors

Urinary Incontinence – Health Outcomes Survey (HOS)

UI, which can be associated with decreased quality of life, affects up to 30% of elderly people; and 85% of long-term care facility residents. However, the true incidence of this disorder may be underestimated due to the social stigma of UI or the assumption that UI is a normal part of aging. On the HOS survey beneficiaries are asked four questions about UI. Two Questions ask about conversations beneficiaries have had with their doctors:

1. ***Have you ever talked with a doctor, nurse, or other health care provider about leaking of urine?***
2. ***There are many ways to control or manage the leaking of urine, including bladder training exercises, medication, and surgery. Have you ever talked with a doctor, nurse, or other health care provider about any of these approaches?***

Because UI is often a sensitive and embarrassing topic for many patients, they may not initiate the discussion if they are experiencing issues with UI. Therefore, we are looking to our providers to start these conversations with our members, which in turn may help them feel more comfortable discussing these issues. **Simply ask them, "Have you ever leaked urine?"** This simple question may be all it takes to reduce their risk of getting UTIs, suffering from depression, or being institutionalized, and may just result in their having an overall better quality of life.

Other Plan Interventions

- **Member Outreach Campaigns -**
  - Phone Messaging Blasts – Flu, Pneumonia, Screenings
  - Text Message Reminders – Conditions and Newly Discharged Members
  - Postcard Reminders - Flu, Pneumonia, Screenings
  - Health Fairs offering flu shots and screenings
  - Member Incentives
- **Provider Performance Reports** – Sent to all PCPs who have members assigned to them
- **Record Collection** – Accessing internal member records to meet Care Gaps

Our **Quality Management** department has many ongoing initiatives to improve health outcomes for our members, including notifying providers of at-risk members.

✓ If you would like to work with Quality Management or have any questions about **HEDIS or any other Star** measures, please contact our Quality Department directly by email at VIPQuality@selecthealthofsc.com.

Provider Performance Reports

Improving the health and well-being of our members is the mission of First Choice VIP Care. You are a valued provider, and we are honored to partner with you toward improving the health of our members.

In order to help achieve this goal First Choice VIP Care generates Provider Performance Reports and HEDIS non-compliant member lists for your review. This notice serves as a reminder to look for these reports in your mail towards the end of each month. These reports are also available on NaviNet for you to review anytime. Please use the following steps to review the reports in NaviNet:

1. Under the Report Inquiry workflow options choose “Administrative Reports”.
2. Choose “PCP Performance Report Card” from the drop-down menu and hit select.
3. Under Choose a “Provider Group” locate your office/group from the drop-down menu.
4. Under “Select Report Type” select “Current” and hit Search.
5. Open the PCP Performance Report Card when prompted.

Please note the reports on NaviNet are refreshed by the 20th of each month.

Medicare Advantage
Risk Adjustment

FirstChoice VIP CARE
by Select Health of South Carolina

Medicare Advantage Risk Adjustment

What is risk adjustment?

- Risk adjustment is method used by the Centers for Medicare & Medicaid Services (CMS) to account for the overall health and expected medical costs of each individual enrolled in a Medicare Advantage (MA) plan.
- CMS uses this method to pay MA plans on a capitated basis for medical care and separately for prescription drug benefits per beneficiary.
- Risk adjustment accounts for beneficiary differences by adjusting these capitated payments (*more or less*) to the MA plan. Payments reflect the specific characteristics of each enrolled beneficiary, including demographics, Medicaid eligibility, and health status.

Why Is Risk Adjustment Done?

- To accurately reflect the health of each MA plan's membership.
- To ensure MA plans have adequate resources to reimburse providers treating MA beneficiaries.
- So MA plans can rely on predictable and actuarially sound payments from CMS in order to provide enough resources to treat and manage all beneficiaries.

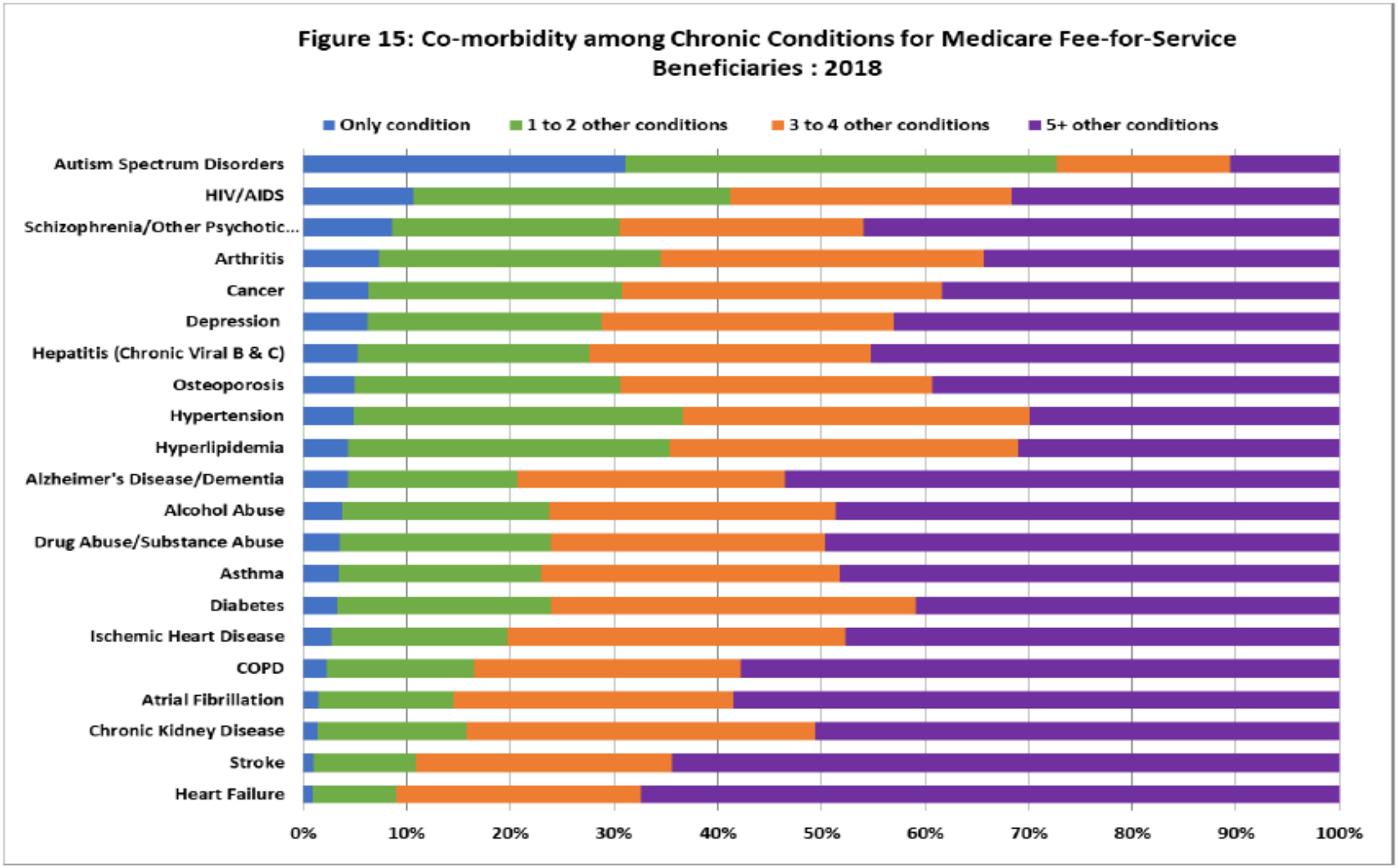
What Methodology Is Used for Risk Adjustment?

- CMS uses a disease model to determine a risk "score" for each member. The model takes individual diagnosis codes and combines them into broader diagnosis groups, which are then refined into **Hierarchical Condition Categories (HCCs)**. HCCs, together with demographic factors such as age and gender, are used to predict beneficiaries' total care costs.
- This system is prospective, which means it uses a beneficiary's diagnoses from one year to calculate a risk adjustment factor used to establish a payment for the following year.
- Each January starts a "clean slate" for HCCs. A non-resolving chronic condition diagnosis (such as diabetes) must be reported on a claim denoting a face to face visit with an acceptable type of provider, in an acceptable setting, at least once during the calendar year. If it is not reported this is called "falling off".

Understanding Hierarchical Condition Categories (HCCs)

- Implemented by CMS in 2003.
- Measures the disease burden that includes **86** HCC categories, which are groups of clinically related diagnosis (ICD-10) codes with similar cost implications.
- The HCC model is made up of 10,000+ ICD-10 codes that typically represent costly, **chronic** diseases such as:
  - ✓ Diabetes
  - ✓ Chronic kidney disease
  - ✓ Congestive heart failure
  - ✓ Chronic obstructive pulmonary disease
  - ✓ Malignant neoplasms
  - ✓ Some acute conditions (MI, CVA, hip fracture)
- ICD 10 to HCC Crosswalk resource: https://www.nber.org/data/icd-hcc-crosswalk-icd-rxhcc-crosswalk.html

Percent of Co-Morbidities



*Example: Heart failure – Only = 1%, 1 to 2 = 9%, 3 to 4 = 26%, 5+ = 64%

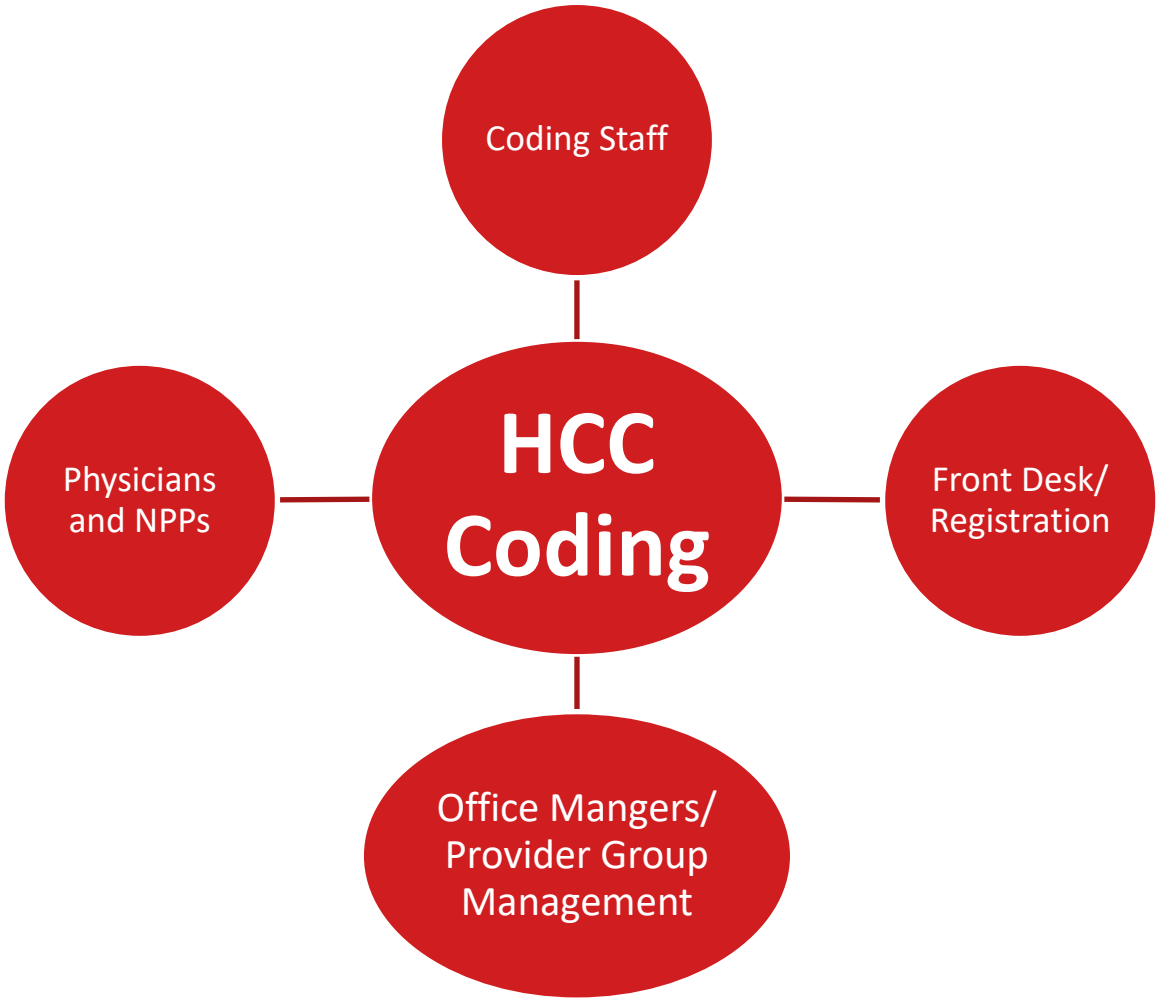
https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Chartbook_Charts

How Can This Help Beneficiaries?

Risk adjustment is much more than a regulatory requirement. It actually improves quality of care in several ways. Accurate identification of patient health status allows us to:

- Understand patient needs, so new programs and interventions can be developed.
- Identify high-risk patients for disease and intervention management programs.
- Ensure that chronically ill beneficiaries receive the most clinically appropriate care.
- Integrate clinical efforts with clinics and provide more robust data.

Who in the provider's office influences HCC coding?



How Can Providers Help?

To comply with CMS regulations, provide the best and most efficient service to your patients, and receive the reimbursements you deserve, here are some steps you can take:

- **Master HCC coding** - Providers should become familiar with the principals of risk adjustment and the impact it has on the health care system.
- **Understand your patient population** – If you serve Medicare patients, it's more than likely many of them have been diagnosed with diabetes, vascular disease, or one or more of the other most common HCC diagnoses. Take a look at your patients and determine who belongs in what diagnosis category.
- **Capture comorbidities** - Because risk adjustment is dependent on diagnosis coding, it is very important that all chronic, acute, and status conditions are documented during each face-to-face encounter.
- **Focus on accuracy** - All diagnosis codes should be coded to the highest specificity and all encounters should be submitted to the health plan.

How Can Providers Help? (Continued)

- **Medical Records**
  - ✓ Document clearly and concisely how the conditions coded were assessed, monitored, or treated, or how they affected the patient's care or your medical decision-making during the visit.
  - ✓ Make sure all medical record entries have a valid signature with credentials (e.g., "M.D.,") and dates for each encounter per CMS guidelines.
  - ✓ Become familiar with standard coding principals for your specialty and make sure that all reported diagnosis codes are clearly supported in the medical record to protect from audits and potential fraud.
- **Report every year** – The CMS risk adjustment model is built on reviewing a previous year's health status to predict the following year's health expenses. That means physicians and practices must report their information every year. Get in the habit of using HCC codes and submitting accurate information in a timely fashion.

Medicare Annual Wellness Visit

Documentation Requirements – MEAT vs TAMPER

MEAT

- Monitor – signs, symptoms, disease progression/regression
- Evaluate – test results, medication effectiveness, response to treatment
- Assess – ordering tests, discussion, review of records, counseling, refer to another provider
- Treat – medications, therapies, other modalities

TAMPER

- Treat – medications, therapies, other modalities
- Assess – ordering tests, discussion, review of records, counseling
- Monitor – signs, symptoms, disease progression/regression
- Plan – what is being done about the patient's condition
- Evaluate – test results, medication effectiveness, response to treatment
- Refer – sending the patient to another provider for treatment of the condition

At least <u>one</u> element of MEAT/TAMPER must be documented for each coded condition to qualify for HCC

Key Points for Documentation

Diagnosis(es) must be:

- Reported at least once each year
- Captured in a face-to-face setting
  - Telehealth by video qualifies
  - Telehealth by audio only does not qualify
- Documented in the health record with appropriate identification, date, and provider signature

Examples:

- OK to capture:
  - Acute conditions that receive care and management during the encounter
  - Chronic conditions, as long as there is continued treatment and care
- Not OK to capture:
  - Conditions that have resolved or are no longer receiving treatment

Risk Adjustment Most Commonly Missed Conditions

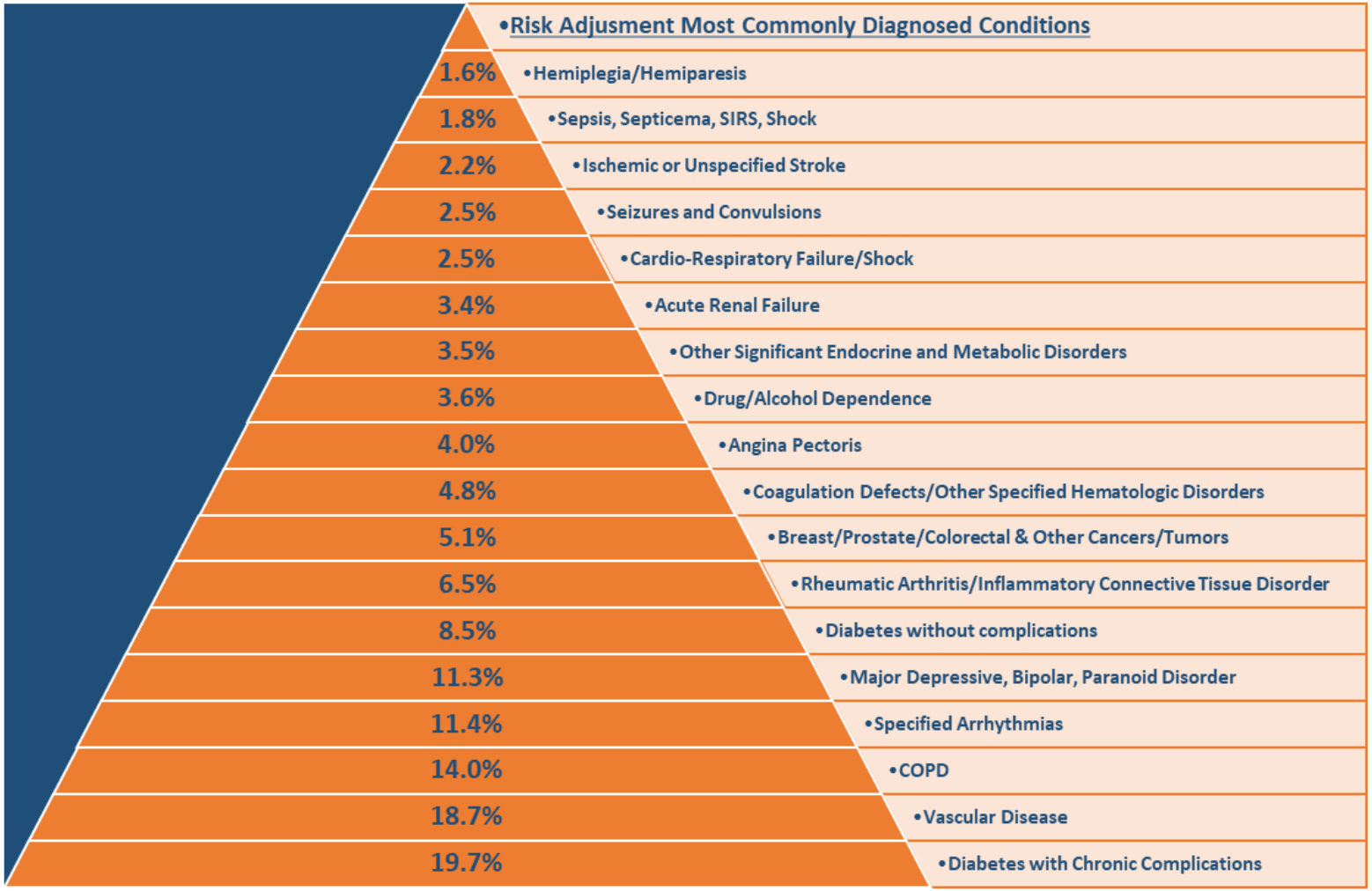
- Diabetes ***without*** complications
- Depression
- Unspecified conditions
- Status conditions – T.O.A.D conditions
  - Transplant
  - Ostomy
  - Amputation
  - Dialysis

Risk Adjustment Common Errors

Common errors in high-risk diagnoses that are reported, but not validated in medical documentation:

- Cancer – Codes as Active/Current vs. History of
- Acute Stroke in outpatient setting vs. History of with residual effects
- Acute Heart Attack in outpatient setting vs. Old Myocardial Infarction
- Embolism – No current medication or treatment documented
- Behavioral Health - Major Depressive Disorder – Over coding with no current treatment or medication documented
- **Mis-keyed diagnosis codes** - ICD-9 diagnosis code 250.00 Diabetes Without Complication transposed as diagnosis code 205.00 Metastatic Cancer and Acute Leukemia

Risk Adjustment Most Commonly Diagnosed Conditions



Risk Adjustment Data Validation (RADV) Audits

RADV audits ensure that health plans are not overstating how sick patients are in order to receive a higher risk-adjusted payment. The audits check to see if HCC codes submitted by MA plans are supported by the member's medical record.

- RADV audits *validate the accuracy of diagnoses* submitted by MA plans.
- Medicare and Medicaid require annual RADV audits.
- If you treated a member whose name appears in a RADV audit, you must provide the requested medical records to the MA plan.
- **Success = accurate chart notes to support every chronic condition reported.**
- **Average error rate nationally is 20–30%.**

Medicare Advantage Plans Are Here to Stay

- 26+ million Medicare beneficiaries are in a MA plan nationwide (42%)
- This number will increase over time partly because MA plans:
  - ➢ Focus on preventive care and early intervention and are incentivized to provide high-value care to keep beneficiaries healthy and minimize disease progression.
  - ➢ Develop innovative models, such as care and disease management programs.
  - ➢ Address chronic diseases by encouraging providers to identify, manage, and treat chronic illness in innovative cost-effective ways, producing high-quality outcomes.
  - ➢ Experience a more clinically appropriate use of health care services than beneficiaries in Fee-for-Service (FFS) Medicare. For example, MA beneficiaries:
    - ✓ Experience lower incidence of emergency services, hospital admissions and readmissions, and receive fewer hip and knee replacements.
    - ✓ Are 20% more likely to have an annual preventive care visit, have improved PCP services and higher rates of screening and outcome metrics for chronic diseases.

Why Risk Adjustment Is Here to Stay

- MA plans are here to stay.
- The healthcare industry is moving from a fee-for-service to a pay-per-performance system – value-based contracting.
- Is also being used under ACA and Medicaid – so it affects more than just Medicare patients.
- Documentation and coding will increasingly drive reimbursement, quality measures, and medical home models.

Disability Competency Training for Medical, Behavioral, and Pharmacy Providers

A quick guide on Disability Competency Training for Medical, Behavioral, and Pharmacy providers

FirstChoice VIP CARE
by Select Health of South Carolina

What Is a Disability?

Disability is the consequence of an impairment that may be:

- Physical
- Cognitive
- Mental
- Sensory
- Emotional
- Developmental
- Or some combination of these

A disability may be present from birth or occur during a person's lifetime.

The Disability Experience

14% of adults in the U.S. have a disabling condition resulting in complex activity limitations which make them more likely to:

- ✓ Live in poverty.
- ✓ Experience material hardship.
- ✓ Have food insecurities.
- ✓ Not get needed medical or dental care.
- ✓ Not being able to pay rent, mortgage, and utility bills.

This population is:

- ✓ Disproportionately represented in racial and ethnic minority groups.
- ✓ Growing in numbers as the population ages and with technological advancements in care.

The Disability Experience (Continued)

People with disabilities are more likely to:

-Experience difficulties or delays in getting the health care they need.

-Not have had an annual dental visit.

-Not have had a mammogram in the past 2 years.

-Not have had a Pap test within the past 3 years.

-Not engage in fitness activities.

-Have high blood pressure.

Source: Healthy People 2020 website http://www.healthypeople.gov/2020/topicsobjectives2020/nationalsnapshot.aspx?topicId=9

The Healthcare of Individuals With Disabilities

Care is at times:

-Reactive.

-Fragmented.

-Inaccessible.

-Standardized/uniform.

Resulting in:

-Avoidable costs, both human and financial.

-Misaligned incentives, leading to increasing costs.

-Ineffective or nonexistent primary care.

Disability Competent Care and Providers

Providers of health care should understand the member's:

1. Experience of being disabled.
2. Disability itself – clinically.
3. Functional limitations due to the disability.

The First Choice VIP Care Member Rights

First Choice VIP Care members all need and expect:

-Right care.

-Right place.

-Right time.

The First Choice VIP Care Member's Access to Healthcare

These rights are achieved by providing:

Availability - Ability to get needed services in a timely manner.

Awareness - Awareness of specific services.

Access to Care - Ability to access available care.

First Choice VIP Care Primary Care Requirements

Responsive Primary Care is the practice of providing timely access to care and services in a variety of settings:

-Enhanced primary care with flexible and extended hours that will assist members in accessing care.

-24/7 urgent and emergent care for members.

-Access to informed and knowledgeable clinicians with electronic health records capability.

-Focus on early intervention to prevent complication or exacerbation of chronic conditions.

-Active participation in the Interdisciplinary Care Team with aggressive transition planning and follow-up.

-Accessible physical facilities, with essential adaptive equipment and flexible scheduling.

Barriers for the Members With Disabilities

Appropriate access to health care for members with disabilities involves addressing additional barriers:

1. Attitude.
2. Communication.
3. Office Location Accessibility.
4. Physical Barriers to Care/Equipment Access.
5. Navigating the Healthcare Setting.
6. Behavioral Health Barriers.

Without Appropriate Accessibility

Members with disabilities can experience:

-Frustration.

-Fatigue.

-Failure.

-Fear.

Poor quality:

-Lack of care.

-Delayed diagnosis.

-Deteriorating health.

Attitude - The Social Model of Disability

Many people have beliefs, biases, prejudices, stereotypes and fears regarding disability, known as ableisms.

Providers need to be aware of their 'ableisms':

-Ingrained perceptions which can affect interactions.

-Impact the care offered or provided.

"Stereotypes are based on assumptions that run deep in our culture — so deep that they can slip by unnoticed unless our awareness is continually sharpened & refined". - Matina S. Horner

Attitude

Common stereotypes & beliefs about people with disabilities include that they are:

- Sick.
- Fragile.
- Unable.
- Helpless.
- Depressed.
- Asexual.
- Outcasts.
- Need charity and welfare.
- Lack skills & talents.
- Homebound.
- Biologically inferior.
- Mentally weak.

Attitude - Allowing it to Affect the Member

- “There is no reason for someone like you to be tested for AIDS.”
- “But this is an ambulatory care clinic.”
- “My, aren’t you cute.”
- “It’s best you not have children.”
- “You don’t have to worry about osteoporosis because you can’t walk.”
- “Getting a mammogram is hard for you so you can just skip it.”

Communication

Two aspects of communication:

- Engagement and listening.
- Using the right auxiliary aids and services to accommodate for limitations of:
    - Hearing.
    - Sight.
    - Comprehension.

Communication

Usable formats:

- ✓ Braille
- ✓ Large print
- ✓ Text (disk)
- ✓ Audio

Communicating Effectively

Examples of effective directions when prescribing:

- Take in the morning.
- Take at bedtime.
- Take 3 times a day with meals.
- Place drops in lower eyelid.

Use teach back techniques to ensure the member understands their prescription instructions.

Communicating Effectively - What Is CLAS?

Culturally and Linguistically Appropriate Services (CLAS) addresses the needs of racial, ethnic, and linguistic population groups based on:

Title VI of the Civil Rights Act of 1964:

"No person in the United States shall, on ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."

Office of Minority Health's National CLAS Standards:

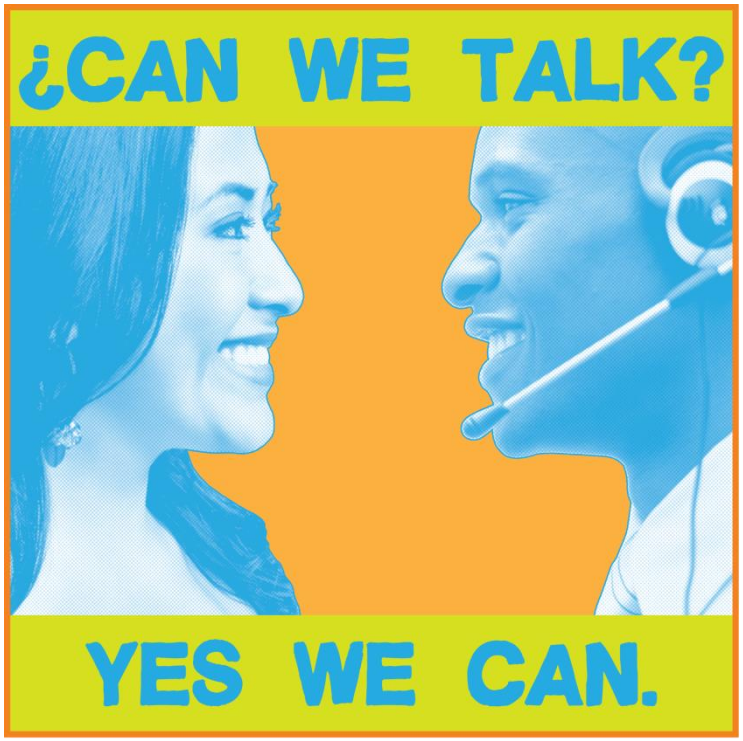
Organized into 4 categories:

- Principal Standard
- Governance, Leadership, and Workforce
- Communications and Language Assessment
- Engagement, Continuous Improvement, and Accountability

First Choice VIP Care CLAS Program

- Associate education and training.
- Provider education and outreach.
- Service delivery and member outreach.

Interpretation Services



Free language services for First Choice members anywhere, anytime.

Call Member Services 1-888-996-0499 OR

the 24 Hour Nurse Help Line 1-(855)-843-1147 to be connected.

Office Location Accessibility

Office Location Accessibility

- Provider offices must be aware and able to communicate public transportation options for members.
- Parking options will include the ADA number of approved handicap parking stalls relative to the building capacity.
- Curb ramps or slopes for pedestrian walkways.
- Automatic doors openers.

Physical Barriers to Care/Equipment Access

Healthcare facilities will utilize accessible office furniture and clear and accessible signage such as:

- Front desk accessibility.
- Permanent signs for handicap accessible areas.
- Flashing alarm systems.
- Visual doorbells and other notification devices.
- Volume control telephones.
- Assistive listening systems.
- Raised character and braille elevator controls.

Physical Barriers to Care/Equipment Access (Continued)

Attention needs to be given to barriers in the delivery of care.

- Accessible exam rooms.
    - Entry doors.
    - Clear floor and turning space.
- Adjustable and accessible exam tables.
- Transferring equipment.
- Accessible scales.
- Accessible radiological and mammography devices.

Physical Barriers to Care/Equipment Access (Continued)

Attention needs to be given to accessing settings of care – from the micro to the macro.

- Maneuvering within exam rooms.
- Maneuvering within offices.
- Accessing the office.
- Accessing to the building in the community.
- People will need to know about the level of physical access that they should expect.

Physical Barriers - Accommodating Members With Disabilities

Providers will ensure member specific accommodations from the moment an individual enters the healthcare delivery system.

Examples include:

- Schedule longer appointment.
- Use lift for transfers.
- Use lift team for transfers.
- Use hi/low table located in specific rooms.
- Use accessible scale.
- Use ASL interpreter.
- Use assistive listening device.

Reviews of Provider Offices

On-site reviews of provider offices found instances of deficiencies including:

- No height-adjustable exam table.
- No accessible weight scale.
- Inaccessible buildings.
- The inability to transfer a member from a wheelchair to an examination table.

Gynecology had the highest rate of inaccessibility for members.

Source: Resources for Integrated Care (website: https://www.resourcesforintegratedcare.com)

Navigating the Healthcare Setting

Patient Navigation is defined as the process(es) by which patients and/or their health caregivers move into and through the multiple parts of the health care enterprise in order to gain access to and use its services in a manner that maximizes the likelihood of gaining the positive health outcomes available through those services. Providers can assist in this process by:

- Assisting members with billing/insurance questions.
- Obtain all necessary referrals/authorizations.
- Keeping members informed about their medical conditions and available treatment options.
- Providing interpretative services for members if needed.

Behavioral Health Barriers

Common behavioral health barriers:

- Too depressed/anxious/paranoid to leave the home.
- Stigma of receiving behavioral health care.
- Psychosocial stressors overwhelming the patient.
- Not feeling welcome at the provider office.
- Lack of identification of comorbid conditions.
- Fragmented funding.
- Lack of collaboration between medical and behavioral health providers.

Behavioral Health Crisis Prevention

Expect and plan for crises and setbacks; it is part of the recovery process.

Develop a safety plan to identify triggers to decompensation, actions to minimize the triggers and actions to take when those triggers occur.

Identify and engage natural and formal supports as part of the safety plan.

- Who can the member call?
- Who can come to the home to care for children/pets if the member needs to be hospitalized?
- Who can take the member to the ER?

Behavioral Health Crisis Treatment

DO:

- Ensure that the space is safe for you and the member; no weapons or items that can be easily used to threaten/hurt self/others. Assess safety of yourself and the member constantly.
- Communicate calmly and softly.
- Communicate warmth; show that you care; smile; open body language.
- Establish a relationship: introduce yourself; ask the member what they want to be called.
- Use closed-ended questions and explain why you are asking; stop asking questions if the member becomes agitated.
- Use active listening skills.
- Speak to the member respectfully: be polite, do not make assumptions about their character or issues, do not over praise; use positive language.

Behavioral Health Crisis Treatment (Continued)

DO NOT:

- Demand they listen or obey you.
- Become agitated or loud.
- Force them to share details or stories with you.
- Give simple reassurances like “everything will be fine”.
- Tell them what they should feel or do.
- Make promises you cannot keep.

Behavioral Health – Post Crisis

1. Evaluate safety plan; what worked, what did not (avoid blaming, just identify); tweak safety plan as needed.
2. Re-engage the member in treatment process.
3. Ensure the member knows that this does not mean their recovery process is completely derailed; crisis is part of the recovery process and it was expected. The goal is to get back into the plan as soon as possible.

Person-Centered Planning

- The member/caregiver knows their issues best and should be in control of all aspects of treatment planning, including:
    - Who is on their treatment team.
    - Preferred site for appointments and meetings.
    - Goals and interventions.
    - What success looks like.
- Focus is on engaging the member/caregiver and empowering them to lead the treatment team.

Self-Determination

- Member determines what recovery/success looks like for them.
- Member/caregiver knows their situation best and, therefore, are the best able to identify goals and interventions that will work for them/their family.
- Empowering the member to lead their treatment.
- Providing supports to help the member reach their own vision for success.

Independent Living Philosophy

- Belief that people with disabilities have a common history and a shared struggle and that we are a community and culture that will advance further banded together.
- Emphasis on consumer control – people with disabilities are the best experts on their own needs.
- People respond better to treatment when they can remain in their community and connected to their natural supports.
- People with disabilities do not see themselves as problems to be solved and ask only for the same human and civil rights enjoyed by others.

Guiding Principles of the Recovery Model

- There are many pathways to recovery.
- Recovery is self-directed and empowering.
- Recovery involves a personal recognition of the need for change and transformation.
- Recovery is holistic.
- Recovery has cultural dimensions.
- Recovery exists on a continuum of improved health and wellness.

Guiding Principles of the Recovery Model

- Recovery is supported by peers and allies.
- Recovery emerges from hope and gratitude.
- Recovery involves a process of healing and self-redefinition.
- Recovery involves addressing discrimination and transcending shame and stigma.
- Recovery involves (re)joining and (re)building a life in the community.
- Recovery is a reality. It can, will, and does happen.

Common Questions and Answers

Is it OK to examine a member who uses a wheelchair in the wheelchair, because the member cannot get onto the exam table independently?

Generally no. Examining a member in their wheelchair usually is less thorough than on the exam table, and does not provide the member equal medical services.

Common Questions and Answers (Continued)

Is it OK to tell a member who has a disability to bring along someone who can help at the exam?

No. If a member chooses to bring along a friend or family member to the appointment, they may. However, a member with a disability, just like other individuals, may come to an appointment alone, and the provider must provide reasonable assistance to enable the individual to receive the medical care.

The provider should ask the member if he or she needs any assistance and, if so, what is the best way to help.

Common Questions and Answers (Continued)

If the member does bring an assistant or a family member, do I talk to the member or the companion? Should the companion remain in the room while I examine the member and while discussing the medical problem or results?

You should always address the member directly, not the companion, as you would with any other member. Just because the member has a disability does not mean that he or she cannot speak for himself or herself or understand the exam results. It is up to the member to decide whether a companion remains in the room during your exam or discussion with the member.

Common Questions and Answers (Continued)

Can I decide not to treat a member with a disability because it takes me longer to examine them or because I don't have accessible medical equipment?

No, you cannot refuse to treat a member who has a disability just because the exam might take more of your or your staff's time. Some examinations take longer than others, for all sorts of reasons, in the normal course of a medical practice. Also, providers may not deny service to a member whom you would otherwise serve because they have a disability.

Common Questions and Answers (Continued)

I have an accessible exam table; but ,if it is in use when a member with a disability comes in for an appointment, is it OK to make the member wait for the room to open up, or else use an exam table that is not accessible?

Generally, a member with a disability should not wait longer than other members because they are waiting for a particular exam table. If the member with a disability has made an appointment in advance, the staff should reserve the room with the accessible exam table for that member's appointment. The receptionist should ask each individual who calls to make an appointment if the individual will need any assistance at the examination because of a disability. This way, the medical provider can be prepared to provide the assistance and staff needed. Accessibility needs should be noted in the member's chart so the provider is prepared to accommodate the member on future visits as well.

Common Questions and Answers (Continued)

In a doctor's office or clinic with multiple exam rooms, must every examination room have an accessible exam table and sufficient clear floor space next to the exam table?

Probably not. The medical care provider must be able to provide its services in an accessible manner to individuals with disabilities. In order to do so, accessible equipment is usually necessary. However, the number of accessible exam tables needed by the medical care provider depends on the size of the practice, the member population, and other factors.

Common Questions and Answers (Continued)

If I lease my medical office space, am I responsible for making sure the examination room, waiting room, and toilet rooms are accessible?

Yes. Any private entity that owns, leases or leases to, or operates a place of public accommodation is responsible for complying with Title III of the ADA. Both tenants and landlords are equally responsible for complying with the ADA.

Conclusion

Access to care enables quality of care… and it's the law!

Engage and listen to the consumer – they will often know how to address the barrier.

Real access is not just installation!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