The Advantage

A Newsletter for Providers

Americans with Disabilities Act — Access to medical facilities

In 1990, President George H.W. Bush signed the Americans with Disabilities Act (ADA), which prohibits discrimination in everyday activities against individuals with disabilities. Title II and Title III of the ADA require hospitals and medical offices to provide "full and equal access" to all health care services and places and to make "reasonable modifications to policies, practices and procedures when necessary to make health care services fully available to individuals with disabilities."

Ease of access to medical facilities is especially important for people with disabilities. Given that people with disabilities often have complex medical conditions that require more frequent visits to medical facilities, it is especially important for hospitals and medical offices to improve their accessibility. Medical facilities should offer some unique accommodations to make the practice and office ADA-compliant.

Standard requirements:

- Designated handicapped parking spaces near facility.
- Pull-up areas for vans and buses for drop-off.
- Curb cuts in sidewalks and entrances.
- Ramps, if needed.
- Elevators, if needed.
- Widened doorways for wheelchair or stretcher access.
- Hallways with 36 inches of clear width.
- Handrails along walls.
- Toilet stalls with grab bars, raised toilet seats, and space to maneuver wheelchairs or other mobility aids.
- Furniture arrangements to provide clearance for wheelchairs and other mobility aids.

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Table of contents

Exam rooms: Not all exam rooms need to accommodate wheelchairs, stretchers, or other mobility aids, but at least one should meet the following requirements:

- Door width — 32 inches when door opened to 90 degrees.
- 60-inch by 60-inch space for wheelchairs to turn around.
- Exam table that can be lowered to the height of a wheelchair seat (17 – 19 inches) and has straps, handrails, or cushions to provide support and safety.
- 30-inch by 48-inch space next to exam table to allow patients to move from wheelchair to table.
- Lift to move patients from chair to exam table.
- Floor scale for wheelchairs.

Disabilities not associated with mobility (e.g., vision, hearing)

- TDD phone — Telecommunication for patients who are deaf.
- Assistance by staff or other technology for reading and completing forms for patients who are blind or have low vision:
  - Large print option available for forms and educational materials.
  - Audio tools for assistance with forms and educational materials.
- "Accessible" or adaptive websites:
  - Add text to images.
  - Allow for adjustment in font size.
  - Allow for adjustment in contrast.
  - Use audio descriptions if possible.

According to the Centers for Disease Control and Prevention (CDC), approximately a quarter of Americans (61 million) have a disability that affects their day to day life. These disabilities include impairments to:

- Mobility.
- Cognition.
- Hearing.
- Vision.
- Independent living.
- Self-care (e.g., dressing and bathing).

It is essential for health care providers to recognize and address these disabilities. People with disabilities have a unique set of challenges that can significantly impact their health. Studies show that people with disabilities report:

- Poorer overall health.
- Reduced access to adequate health care.
- Behaviors that impact their health, including smoking and physical inactivity.

The medical profession is devoted to caring for the ill, but too frequently people with disabilities do not receive the same level of care as nondisabled people. The health care system is often not equipped to optimally care for people with disabilities or recognize the stigma associated with disability. Making medical facilities and practices more accessible to disabled people, and increasing awareness and understanding of this population at all levels of the health care system, will help remove some of the barriers people with disabilities face and thus improve their health outcomes.

Care for patients with disabilities is often more complex, requiring additional resources and increased coordination. Providing a higher level of care for this group will require improving provider training, conducting more health research with people with disabilities, developing best practices, advancing technology (especially communication technology), and designing models of care for practices to develop the skills and capacity to meet the special needs of this population. Healthy People 2020, the current version of a set of goals and objectives released by the U.S. Department of Health and Human Services every decade, has defined one of its goals, "to maximize health, prevent chronic disease, improve social and environmental living conditions, and promote full community participation, choice, health equity, and quality of life among individuals with disabilities of all ages." This is an ambitious but important goal, as improving the health of individuals with disabilities will result in healthier communities with long-term and widespread benefits. Health care organizations and health care providers must lead the way by removing barriers and implementing practices that improve the health and well-being of people with disabilities.

Sources:
"CDC: 1 in 4 US Adults Live with a Disability," Centers for Disease Control and Prevention, August 16, 2018, https://www.cdc.gov/media/releases/2018/p0816-disability.html.

"Disability and Health — People with Disabilities," Centers for Disease Control and Prevention, August 09, 2018, https://www.cdc.gov/ncbddd/disabilityandhealth/people.html.

"Disability and Health," Healthy People 2020, https://www.healthypeople.gov/2020/topics-objectives/topic/disability-and-health.

"Access To Medical Care For Individuals With Mobility Disabilities," Americans with Disabilities Act website, July 22, 2010, https://www.ada.gov/medcare_mobility_ta/medcare_ta.htm.

"Questions and Answers about Health Care Workers and the Americans with Disabilities Act," Equal Employment Opportunity Commission, https://www.eeoc.gov/facts/health_care_workers.html.

Coding Corner: Hypertensive disease and ICD-10-CM

Claims analysis shows that hypertensive disease is a frequently under-coded diagnosis. Coding correctly for hypertension using the **International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)** can be daunting unless you know the rules. But correct coding is important for many reasons, including:

- Adherence to **ICD-10-CM** coding conventions for reporting diagnoses is required under Health Insurance Portability and Accountability Act (HIPAA) regulations[1].
- It is vital for managed care organizations to have accurate and complete hypertension diagnosis data on file to provide optimum care management and coverage.

When coding hypertension, it is important to consider the official guidelines in the ICD-10 manual, which include instructions about "causal relationships". When assigning diagnosis codes for hypertension, in most cases there is a presumed causal relationship between hypertension and heart involvement, and between hypertension and kidney involvement. In this case, the presumption allows coders to associate hypertension with chronic heart and/or chronic kidney disease even when the medical record does not definitively indicate they are related[2].

Below is a quick reference guide to correct coding for hypertensive disease.

Hypertensive disease coding guide[3]

Hypertension	Heart disease	Heart failure	Kidney disease	ICD-10-CM code
Yes	No	No	No	I10, (accelerated) (benign) (essential) (idiopathic) (malignant) (systemic) Hypertension
Yes	Yes	No	No	I11.9 Hypertensive heart disease without heart failure
Yes	Yes	Yes*	No	I11.0, Hypertensive heart disease with heart failure
Yes	No	No	Yes**	I12.9, Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease or unspecified chronic kidney disease.
Yes	No	No	Yes**	I12.0, Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease
Yes	Yes	Yes*	Yes**	I13.0, Hypertensive heart and chronic kidney disease with heart failure and with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
Yes	Yes	Yes*	Yes**	I13.2, Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end-stage renal disease
Yes	Yes	No	Yes**	I13.10, Hypertensive heart and chronic kidney disease without heart failure and with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease.
Yes	Yes	No	Yes**	I13.11, Hypertensive heart and chronic kidney disease without heart failure and with stage 5 chronic kidney disease, or end-stage renal disease

*Also requires type of heart failure to be coded — Category I50
**Also requires type of kidney disease to be coded — Category N18

[1]"HIPAA administrative simplification: modifications to medical data code set standards to adopt ID-10-CM and ICD-10-PCS. Final rule," *Federal Registry* 74, no. 11 (2009): 3328 – 62, https://www.ncbi.nlm.nih.gov/pubmed/19385111.

[2]Carol J. Buck, *CD-10 CM Official Guidelines: 2018 ICD-10-CM For Hospitals* (Elsevier, 2018), p. 18.

[3]Kenneth D. Beckman, "How to Document and Code for Hypertensive Diseases in ICD-10," *Fam Pract Manag* 21, no. 2 (2014): 5 – 9, http://www.aafp.org/fpm/2014/0300/p5.html.

Coding Corner: Neoplasm disease — current vs. personal history

First Choice VIP Care Plus claims analysis reveals that malignant neoplasm or "active cancer" is a frequently over-coded diagnosis. It's important that accurate coding and correct documentation are used to distinguish between an active malignancy versus personal history of a malignancy. As you know, complete and correct coding is important for many reasons, including:

- It helps reduce future medical record inquiries for audits to support the reporting of chronic conditions.
- Adherence to ICD-10-CM coding conventions for diagnosis reporting is required under HIPAA regulations.[1]
- It is vital for managed care organizations to have accurate and complete neoplasm diagnosis data on file to provide optimum care management for health plan members.

Guidelines

Accurate coding of neoplasm disease requires understanding of the Centers for Medicare & Medicaid Services (CMS) ICD-10-CM official guidelines in the ICD-10 manual. Please follow the quick reference guide and examples below when coding for neoplasm disease:

- **Active/current malignant neoplasm** — Assign the correct active neoplasm code for the primary malignancy until treatment is completed. This applies even when the primary malignancy has been excised but further treatment (e.g., radiation therapy, chemotherapy, or additional surgery) is directed to that site.
- **Personal history of** — When a primary malignancy has been excised or eradicated and there is no further treatment of the malignancy directed to that site, and there is no evidence of any existing primary malignancy, a code from category Z85 indicating there is a personal history of malignant neoplasm should be used for the site of the former malignancy.

  Note: leukemia, multiple myeloma, and malignant plasma cell neoplasms — Don't confuse personal history with being "in remission." Codes for leukemia, multiple myeloma, and malignant plasma cell neoplasms are considered active conditions and must indicate whether the condition has achieved remission. Assign a code for personal history of leukemia when the physician documents that the leukemia no longer exists. The codes for "personal history" and "in remission" are only assigned when documented by the provider.

The "ICD-10-CM Table of Neoplasms" in the alphabetic index of the CMS ICD-10 CM official guidelines in the ICD-10 manual lists the codes for neoplasms by anatomical site. For each site, there are six columns of codes identifying whether the neoplasm is malignant (primary and secondary), benign, in situ, uncertain, or unspecified behavior. Certain benign neoplasms, such as prostatic adenomas, may be found in the specific body system chapters.

Examples

1. **Situation:** Medical documentation states patient admitted to rule out metastatic bone cancer originating from the breast. The breast cancer was treated with mastectomy and adjunct chemotherapy three years ago.
   Coding example: Report the code that corresponds with a personal history of malignant neoplasm at the former site of the cancer because the breast cancer has been treated and this is not an active diagnosis of breast cancer. (category Z85.)
2. **Situation:** A patient with metastatic bone cancer originating from breast cancer that was eradicated three years ago is admitted for pain management.
   Coding category examples:
   G89 — Neoplasm related pain (acute) (chronic)
   C79 — Secondary malignant neoplasm of bone
   Z85 — Personal history of malignant neoplasm
3. **Situation:** Patient with leukemia documented as "in remission" is admitted for autologous bone marrow transplantation.
   Coding example: Use the appropriate code to designate the type of leukemia and remission status.

[1]"HIPAA administrative simplification: modifications to medical data code set standards to adopt ID-10-CM and ICD-10-PCS. Final rule," Federal Registry 74, no. 11 (2009): 3328 – 62, https://www.ncbi.nlm.nih.gov/pubmed/19385111.

Adult body mass index (BMI) assessment

Providers treating our members age 18 and older may report completed adult BMI assessments (ABAs) using ICD-10-CM codes. This is an important indicator which can be used to screen for weight categories that may lead to health problems. Below are the ICD-10-CM codes that correspond to particular BMI ranges*.

ICD-10-CM code	BMI range	ICD-10-CM code	BMI range
Z68.1	19.9 or Less	Z68.32	32.0 – 32.9
Z68.20	20.0 – 20.9	Z68.33	33.0 – 33.9
Z68.21	21.0 – 21.9	Z68.34	34.0 – 34.9
Z68.22	22.0 – 22.9	Z68.35	35.0 – 35.9
Z68.23	23.0 – 23.9	Z68.36	36.0 – 36.9
Z68.24	24.0 – 24.9	Z68.37	37.0 – 37.9
Z68.25	25.0 – 25.9	Z68.38	38.0 – 38.9
Z68.26	26.0 – 26.9	Z68.39	39.0 – 39.9
Z68.27	27.0 – 27.9	Z68.41	40.0 – 44.9
Z68.28	28.0 – 28.9	Z68.42	45.0 – 49.9
Z68.29	29.0 – 29.9	Z68.43	50.0 – 59.9
Z68.30	30.0 – 30.9	Z68.44	60.0 – 69.9
Z68.31	**31.0 – 31.9**	**Z68.45**	**70.0 or greater**

*Correct coding and submission of claims is the responsibility of the submitting provider.

Submitting appropriate ICD-10-CM codes helps inform us that you have provided the service, and may decrease the need for the health plan to request medical records from your office. However, please note, if medical records are requested, a provider's documentation of BMI is only valid for health plan data collection purposes if the weight and BMI are from the same data source and are recorded in the medical record during the measurement year or the year prior to the measurement year.

Collecting social determinants of health (SDOH) data to address members' unmet needs

At First Choice VIP Care Plus, care is the heart of our work. That means that every day we put our members and their families first. We work to improve not only their health, but also the economic and social factors that can act as barriers to proper care — social determinants of health that are estimated to account for 70 percent of avoidable mortality[1] in the United States alone.

Our mission to help members build strong, healthy communities goes beyond clinical care. Up to 90 percent of a person's health is tied to factors other than clinical care.[2] These factors, known as the social determinants of health, include access to nutritious food, medical care, safe housing, reliable transportation, and community supports.

These underlying drivers of health impact every part of our physical, mental, and social well-being. When they work against someone or are left unaddressed, they create health inequalities, which lead to worse outcomes and more expensive care.

Social factors, including education, racial segregation and bias, social supports, and poverty, can affect a person's risk factors for premature death and life expectancy. SDOH disproportionately impact low-income individuals and minority populations. As SDOH have a significant impact on health outcomes, addressing the impacts of SDOH is essential to achieving greater health equity.

Health care providers who serve our members are uniquely positioned to identify and address SDOH, and together we can customize person-centered programs to help ensure our members have the critical support and services they need to lead healthier, more productive lives.

Action needed: ICD-10 includes supplemental diagnosis codes that allow you to report SDOH on your claims. Note: SDOH should not be used as the admitting or principal diagnosis.

SDOH description	Applicable ICD-10 codes
Education	**Z550** Illiteracy and low-level literacy **Z551** Schooling unavailable and unattainable **Z558** Other problems related to education and literacy **Z559** Problems related to education and literacy, unspecified
Employment	**Z56.0** Unemployment, unspecified; **Z56.2** Threat of job loss; **Z56.3** Stressful work schedule; **Z56.6** Other physical and mental strain related to work; **Z56.81** Sexual harassment on the job; **Z56.82** Military deployment status; **Z56.4** Discord with boss and workmates;
Housing and economic	**Z590** Homeless **Z591** Inadequate housing **Z592** Discord with neighbors, lodgers, and landlord **Z593** Problems related to living in residential institution **Z594** Lack of adequate food and safe drinking water **Z595** Extreme poverty **Z596** Low income **Z597** Insufficient social insurance and welfare support **Z598** Other problems related to housing and economic circumstances **Z599** Problem related to housing and economic circumstances, unspecified

[1]J.R. Knickman, J.M. McGinnis, and P. Williams-Russo, "The case for more active policy attention to health promotion," Health Affairs 21, no. 2 (2002): 78 – 93, PMID 11900188. See also National Academies Press free publication The Future of Public Health in the 21st Century.

[2]S. Magnan, "Social Determinants of Health 101 for Health Care: Five Plus Five," NAM Perspectives (discussion paper, National Academy of Medicine, Washington, DC, 2017), https://doi.org/10.31478/201710c.

SDOH description	Applicable ICD-10 codes
Social environment	**Z600** Problems of adjustment to life-cycle transitions **Z602** Problem related to living alone **Z603** Acculturation difficulty **Z604** Social exclusion and rejection **Z605** Target of (perceived) adverse discrimination and persecution **Z608** Other problems related to social environment **Z609** Problem related to social environment, unspecified
Upbringing	**Z6221** Child in welfare custody **Z6222** Institutional upbringing **Z6229** Other upbringing away from parents **Z62810** Personal history of physical and sexual abuse in childhood **Z62811** Personal history of psychological abuse in childhood **Z62812** Personal history of neglect in childhood **Z62819** Personal history of unspecified abuse in childhood
Family and social support issues	**Z630** Problems in relationship with spouse or partner **Z6331** Absence of family member due to military deployment **Z6332** Other absence of family member **Z634** Disappearance and death of family member **Z635** Disruption of family by separation and divorce **Z636** Dependent relative needing care at home **Z6371** Stress on family due to return of family member from military deployment **Z6372** Alcoholism and drug addiction in family **Z6379** Other stressful life events affecting family and household
Experiences with crime, violence, and judicial system	**Z650** Conviction in civil and criminal proceedings without imprisonment **Z651** Imprisonment and other incarceration **Z652** Problems related to release from prison **Z653** Problems related to other legal circumstances **Z654** Victim of crime and terrorism **Z655** Exposure to disaster, war, and other hostilities
Inadequate material resources	**Z753** Unavailability and inaccessibility of health care facilities **Z754** Unavailability and inaccessibility of other helping agencies
Contact with and suspected exposure	Z77010 Contact with and suspected exposure to arsenic Z77011 Contact with and suspected exposure to lead Z77090 Contact with and suspected exposure to asbestos Z570 Occupational exposure to noise Z571 Occupational exposure to radiation Z572 Occupational exposure to dust Z5731 Occupational exposure to environmental tobacco smoke Z5739 Occupational exposure to other air contaminants Z574 Occupational exposure to toxic agents in agriculture Z575 Occupational exposure to toxic agents in other industries Z578 Occupational exposure to other risk factors
Stress	Z733 Stress, not elsewhere classified Z734 Inadequate social skills, not elsewhere classified Z7389 Other problems related to life management difficulty Z739 Problem related to life management difficulty, unspecified Z658 Other specified problems related to psychosocial circumstances Z659 Problem related to unspecified psychosocial circumstances

Important information about older adults and opioid medication use

The news is filled with stories about how the misuse of opioids — strong medicines used to treat pain — is causing illness and even death. Most of the focus is on how the issue is affecting young people. But the number of older adults affected by the misuse of opioids such as oxycodone and hydrocodone is quickly growing.

There are certain reasons why older adults are at risk for opioid use disorder. As the body ages, there is a greater chance of getting illnesses like arthritis and cancer. There can also be more injuries, such as broken bones from falling. These illnesses and injuries can cause chronic pain. Health care providers will often prescribe opioids to treat this pain. Some providers tend to prescribe more medicine than is needed for older patients. They may do this because they don't want to see an older person in pain; they may also not understand how much more sensitive an older person's system can be to opioid medication. Some providers may also believe that elderly patients are less likely than younger patients to misuse medicines.

Over time, the effect of these drugs on the brain can lead to opioid use disorder, regardless of a person's age. Plus, many older adults take several medicines — including prescription and over-the-counter medicines — to treat different conditions, which can increase the effect of opioid medication. Other factors putting older adults at risk for opioid use disorder include:

- A lack of social support, which can lead to spending a lot of time alone, especially after the death of a spouse.
- Money problems, which can cause stress and anxiety.
- Memory issues that cause confusion and lead to medicines being taken incorrectly.

Sources:
"Older Adults and Drug Abuse," Hazelden Betty Ford Foundation, March 1, 2015, https://www.hazeldenbettyford.org/education/bcr/addiction-research/older-adults-drug-abuse-ru-315.

Jenny Gold, "Opioids Can Derail The Lives Of Older People, Too," National Public Radio, December 20, 2016, http://www.npr.org/sections/health-shots/2016/12/20/502470255/opioids-can-derail-the-lives-of-older-people-too.

Urinary incontinence

CMS monitors the quality of care for beneficiaries enrolled in Medicare Advantage plans. One method of measuring the quality of care is by surveying beneficiaries through the Health Outcomes Survey (HOS), which surveys beneficiaries on self-reported outcome measures at the beginning and end of a two-year period.

One area of inquiry on the HOS survey is urinary incontinence (UI), which can be associated with decreased quality of life. UI affects up to 30 percent of elderly people, and 85 percent of long-term care facility residents will suffer with UI[1]. 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 the following questions about UI:

1. Many people experience leakage of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine?
2. During the past six months, how much did leaking of urine make you change your daily activities or interfere with your sleep?
3. Have you ever talked with a doctor, nurse, or other health care provider about leaking of urine?
4. 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?

As you can see, questions 3 and 4 ask about conversations beneficiaries have had with their providers. 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 initiate a conversation that can lead to reduced risk of getting urinary tract infections, suffering from depression, or being institutionalized, and may just result in their having an overall better quality of life.

[1]George A. Demaagd and Timothy C. Davenport, "Management of Urinary Incontinence," Pharmacy and Therapeutics, June 2012, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3411204/.

Help optimize care coordination by asking your patients to complete a HIPAA authorization form

Summary: Information sharing for care coordination may require a valid HIPAA authorization form when certain conditions or sensitive disease states are present. The absence of a valid HIPAA authorization form may prevent the health plan and other care team members from providing the most efficient care coordination to your patients. It is important for your patients to understand and complete a HIPAA authorization form. If your practice does not have a version of this form already in use, the health plan can provide one upon request.

Background: The HIPAA Privacy Rule allows covered entities to access, use, or disclose patient protected health information (PHI) for the purposes of payment, treatment, and health care operations. However, it has become common practice for conditions such as mental health disorders, HIV/AIDS, substance use, sexually transmitted diseases, and genetic conditions, to necessitate the affirmative permission of a patient by means of a HIPAA authorization form before diagnostic records or other information can be shared with providers and other partners on the patient's care team.

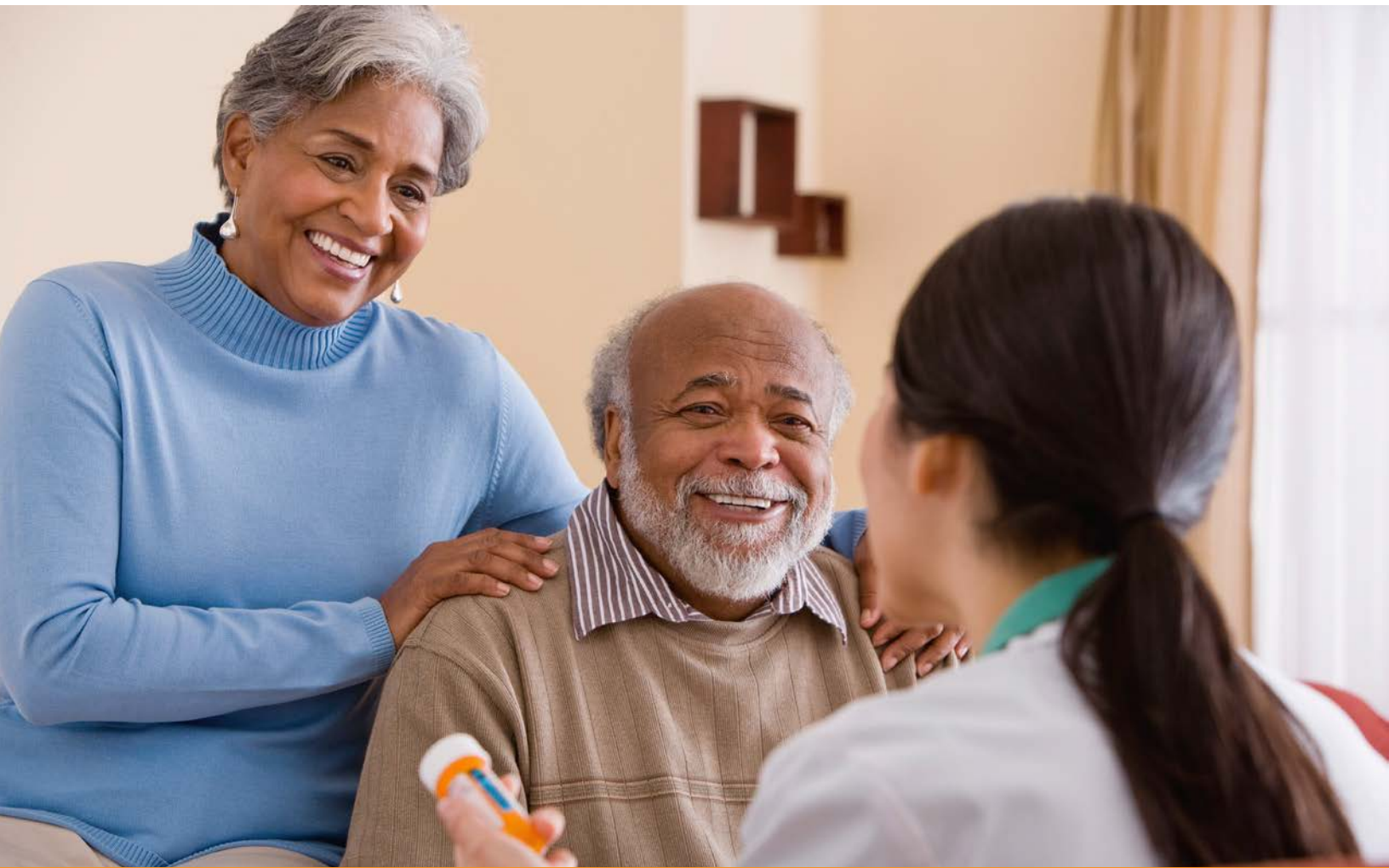
Absence of a valid HIPAA authorization form may prevent the health plan and other care team members from providing the most efficient care coordination to your patients. It is important for your patients to understand and complete a HIPAA authorization form to optimize information sharing for care coordination purposes.

Action needed:

Please tell your patients about the importance of completing a HIPAA authorization form to optimize care coordination, and ask your patients to complete the form while in your office. If your practice does not have a version of this form already in use, First Choice VIP Care Plus can provide you a HIPAA authorization form upon request.

Questions:

If you have questions about this communication or would like to request HIPAA authorization forms, please contact your Provider Network Management Account Executive or Provider Services at **1-888-978-0862**.



Reaching for the stars

In today's world, most people do not go to a restaurant or stay in a hotel without first looking at reviews. You may not be aware of this, but there is also a rating system which can help individuals in choosing a Medicare Advantage plan. It is called the Medicare Five-Star Quality Ratings System. This initiative began in 2007, when CMS developed a quality and financial incentive program that rewards Medicare Advantage plans for quality-related performance. These financial incentives must be used to improve member benefits and/or reduce costs for members enrolled in the health plan. These ratings measures assess quality health care and plan responsiveness, which helps beneficiaries to compare the performance and quality of Medicare Advantage plans.

How are the ratings determined?

- There are 48 measures for Medicare Parts C and D.
- Each measure is rated on a scale of one to five, with five being the highest score.
- Some measures are weighted more heavily than others.
- A combined score gives the overall star-rating measure for the plan. More stars indicate better quality and performance for the types of services each plan offers:

  Five-star rating: Excellent
  Four-star rating: Above average
  Three-star rating: Average
  Two-star rating: Below average
  One-star rating: Poor

What is measured?

For plans covering health and drug services, the overall rating is based on the quality of many health care services that fall into these categories:

- **Staying healthy:** Screening tests and vaccines. Includes whether members got various screening tests, vaccines, and other checkups 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 conditions.
- **Member experience with the health/drug plan services:** Includes member ratings of the plan.
- **Member complaints and changes in the health/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.
- **Health/drug plan customer service:** Includes how well the plan handles member appeals.
- **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 conditions.

Where do scores come from?

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

- Health Care Effectiveness Data and Information Set (HEDIS®) results.
- HOS (member).
- The Consumer Assessment of Healthcare Providers and Systems (CAHPS®; member).
- CMS data sources (eligibility, "secret shopper" surveys, notices).
- Independent review entities (IREs).
- Complaint tracking module (CTM).
- Prescription drug event (PDE) data.
- Medicare Advantage plan reporting.

Top-scoring Medicare-Medicaid Plans (MMPs) on overall rating of health plans: A snapshot from the 2018 CAHPS survey

Select Health of South Carolina's First Choice VIP Care Plus plan has been rated as one of the top five MMPs on overall rating of health plans, based on 2018 CAHPS data.

Under the Medicare-Medicaid Financial Alignment Initiative, CMS is measuring consumer experience in multiple ways, including through beneficiary surveys such as the CAHPS survey. Under the capitated financial alignment model, MMPs must annually conduct the Medicare Advantage Prescription Drug (MA-PD) CAHPS survey. The MA-PD CAHPS survey is designed to measure important aspects of an individual's health care experience including the accessibility to and quality of services.

In order to report MA-PD CAHPS data in a given year, health plans, including MMPs, must have a minimum of 600 enrollees as of July 1 of the preceding calendar year. In early 2018, surveys were sent to a sample of MMP enrollees with at least six months of continuous enrollment. Enrollees were asked to evaluate their health care experience over the previous six months. As a result, 41 MMPs participating in nine capitated model demonstrations were able to report CAHPS data during the 2018 reporting cycle.

As part of the MA-PD CAHPS survey, respondents are asked to rate their health plan on a scale from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible. Survey questions are grouped into categories to reflect satisfaction with service and care as follows:

- Customer Service.
- Courteous Office Staff.
- Doctor Communication.
- Getting Needed Care.
- Getting Care Quickly.
- Rating of Health Plan.
- Rating of Personal Doctor.
- Rating of Specialist.
- Rating of Health Care.

The scores below are the percentage of the best possible score each contract earned.

MMP	State	Score (out of 100)*
Select Health of South Carolina (H8213)	SC	90
Neighborhood Health Plan of Rhode Island (H9576)	RI	90
Commonwealth Care Alliance (H0137)	MA	90
Upper Peninsula Health Plan (H1977)	MI	90
Healthfirst Health Plan (H5441)	NY	89

This customer service data is an important indication of plan performance, and we are thrilled to see First Choice VIP Care Plus as a top scorer! This is a testament to all the hard work the plan does to provide an excellent care experience to our members.

Medicaid home- and community-based services (HCBS) waiver programs — What are they and who made them possible?

Medicaid HCBS waiver programs are state-specific Medicaid programs which help provide long-term care services to people in the community who would otherwise be in a nursing home or hospital. These services are known as long-term services and supports (LTSS) and include services such as personal care to assist with bathing, dressing, and other activities of daily living. Nearly all states and the District of Columbia offer services through HCBS waivers. States can operate as many HCBS waivers as they want — currently, more than 300 HCBS waiver programs are active nationwide.

Prior to 1983, these types of services were prohibited from being covered by Medicaid outside of a nursing home or hospital. This all changed due to one little girl named Katie Beckett and her parents. At 5 months old, she was confined to a hospital for almost three years due to contracting encephalitis and needing the aid of a ventilator to breathe for most of the day. After exhausting private insurance benefits, Medicaid kicked in, but would only cover services within the hospital. Her parents wanted to care for their daughter at home and Katie's doctors agreed; however, the laws prohibited this. Her parents were persistent, and their plight was heard by President Ronald Reagan. The president saw to it that the laws were changed with the passage of Section 1915(c) of the Social Security Act. This law allows states to "waive" the Medicaid laws which prohibit them from providing these "hospital-like" services in the community — hence the name "waiver programs." Katie was able to go home and, despite the odds, lived to age 34, due in part to being able to live at home.

Waiver services are available to eligible First Choice VIP Care Plus members. If your office identifies a patient who is a member of our plan that you believe can benefit from these types of LTSS services, please contact our Care Management department at **1-888-244-5440**.

Developing patient teach-back to improve patient education

Health care providers are implementing teach-back as a way to improve patient health care, rein in skyrocketing health care costs, and reduce the number of calls from patients with follow-up questions.

Teach-back involves providers allowing time for patients to speak back what they learned during an appointment. According to a landmark study published in the *Journal of the Royal Society of Medicine*, patients typically don't remember 40 percent to 80 percent of the information they receive during a health care appointment — and approximately 50 percent of what they remember is inaccurate or has been misunderstood.

A patient's ability to absorb information can understandably be undermined by the stress, for example, of having received a negative diagnosis. When patients have the opportunity to put the information into their own words, they become more engaged and, as a result, are ultimately healthier.

The Agency for Healthcare Research and Quality offers these recommendations:

- Restate the information given in simple language (avoid medical jargon).
- Suggest that the patient put the information in his or her own words.
- Evaluate patient comprehension: "Were there any areas that seemed unclear?"
- Clarify information as needed.

Teach-back also allows the patient's family or caregivers who attend the appointment a chance to reinforce their understanding of the information given. When a patient has an involved and informed care team, the chances of a positive outcome increase. In addition, printouts and digital tools such as videos or digital modules are helpful in allowing the patient and care team to refresh their memories of the education they received after they've left the office.

Source: "Developing Patient Teach-Back to Improve Patient Education," PatientEngagementHIT, December 17, 2018, https://patientengagementhit.com/features/developing-patient-teach-back-to-improve-patient-education?eid=CXTEL**000000368967**.

High-risk drugs for the elderly

Are the providers in your office prescribing high-risk medications for your patients over age 65?

High-risk medications are those identified by the American Geriatric Society's (AGS) Beers Criteria as tending to cause adverse drug events in older adults due to their pharmacologic properties and the physiologic changes of aging.

Prescription drug use by the elderly can often result in adverse drug events that contribute to:

- ✓ Hospitalization.
- ✓ Increased duration of illness.
- ✓ Nursing home placement.
- ✓ Falls and fractures.

Potentially inappropriate medications continue to be prescribed for and taken by older adults despite the recognition of an increased likelihood of adverse drug events and evidence of poor outcomes in elderly patients. First Choice VIP Care Plus would like to work with providers to find safer alternatives for our members over age 65. Please contact member Care Coordinators at **1-888-978-0862**, and we will be glad to assist you.

A printable pocket guide to these medications is also available from AGS at **https://geriatricscareonline.org/ProductTypeStore/pocketcards/10/**.

Annual Medicare training requirements

- Compliance — CMS requires that everyone who provides health care or administrative services to Medicare enrollees must satisfy general compliance training requirements. Medicare Parts C and D General Compliance Training is available on the CMS website.
- Fraud, waste, and abuse — CMS requires our first-tier, downstream, and related entities (FDRs, which include network providers) to complete annual Medicare fraud, waste, and abuse training. To fulfill this requirement, you must use CMS fraud, waste, and abuse online training or incorporate the content of the CMS standardized training modules from the CMS website into your organization's existing compliance training materials and systems.

Balance billing

Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997, prohibits Medicare providers from balance billing qualified Medicare beneficiaries for Medicare cost-sharing. Under the requirements of the Social Security Act, all payments from our plan to participating plan providers must be accepted as payment in full for services rendered. Members may not be balance billed for medically necessary covered services under any circumstances. All providers are encouraged to use the claims inquiry process to resolve any outstanding claims payment issues. Providers may reference CMS MLN Matters number SE1128 for further details.

Report suspected fraud, waste, or abuseto First Choice VIP Care Plus

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

- By phone: **1-866-833-9718**
- By U.S. mail:
  First Choice VIP Care Plus
  Special Investigations Unit
  200 Stevens Drive
  Philadelphia, PA 19113

The First Choice VIP Care Plus Special Investigations Unit supports the efforts of local and state authorities in the prosecution of reported cases of fraud, waste, and abuse. Reports of suspected fraud, waste, and abuse related to First Choice VIP Care Plus may also be sent directly to the U.S. Department of Health and Human Services by calling 1-877-7SAFERX (772-3379). **Information may be given anonymously.**

Important phone numbers

Provider Services: **1-888-978-0862**

Prior authorizations: **1-888-244-5410**
1-888-257-7690 (Fax)

Pharmacy Services: **1-855-327-0512**

Language Line: **1-888-978-0862**

- After hours: **1-877-693-8275**

Fraud, waste, and abuse hotline: **1-866-833-9718**

NaviNet: **1-888-482-8057**

Change Healthcare

- Electronic billing, electronic funds transfer, and electronic remittance advices: **1-877-363-3666**

FirstChoice VIP CARE PLUS by Select Health of South Carolina | Healthy Connections PRIME

www.firstchoicevipcareplus.com

The Advantage

A Newsletter for Providers

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P.O. Box 40849
Charleston, SC 29423

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