Additional Information/Resources
Are your providers prescribing high-risk medications for your patients over age 65?

High-risk medications are those identified by American Geriatric Society (AGS) Beers Criteria which tend 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 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 the member’s care coordinator at 1-888-978-0862, option 5, and we will be glad to assist you.

A printable pocket guide of these medications is also available from AGS at:

Beers Criteria Printable Pocketcard - American Geriatrics Society
What is risk adjustment?

- Risk adjustment is an essential mechanism used in health insurance programs to account for the overall health and expected medical costs of each individual enrolled in a health plan.

- Accounting for the health status of beneficiaries for payment purposes is called risk adjustment and ensures Medicare Advantage (MA) plans have adequate resources to reimburse providers treating MA beneficiaries, including individuals with complex chronic diseases.

- The MA plans rely on risk adjustment to maintain predictable and actuarially sound payments to MA plans in order to provide benefits to all enrollees.

- Risk adjustment accounts for beneficiary differences by adjusting payments to the MA. Payments reflect the specific characteristics of each enrolled beneficiary, including demographics, Medicaid eligibility, and health status.
What methodology is used for risk adjustment?

- The Center for Medicare and Medicaid Services (CMS) pays MA plans on a per enrollee capitated basis for medical care and separately for prescription drug benefits.

- 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.

- 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”.

- 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.
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.
• Integrate clinical efforts with clinics and provide more robust data.
How can provider’s help?

• Providers should become familiar with the principals of risk adjustment and the impact it has on the health care system.
• 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.
• All diagnosis codes should be coded to the highest specificity and all encounters should be submitted to the health plan.
How can provider’s help (cont.)?

- 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.
The advance directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under South Carolina state law, relating to providing health care when an individual is incapacitated.
Member rights under federal law:

• To decide what medical care they want to receive, if in the future they are unable to make their wishes known.

• To choose an individual to act on their behalf to make health care decisions in the event they are unable to make these decisions on their own.
Provider’s responsibilities:

• Discuss and offer to assist with facilitation of advance directives for individuals.*

• Maintain written policies and procedures concerning advance directives with respect to all adults receiving care.

* Must be in compliance with 42 C.F.R. 489.100.
Advance Directives — Provider Responsibilities (cont.)

- Information regarding advance directives must be furnished by providers and/or organizations as required by federal regulations:
  - **Hospital** — At the time of the individual’s admission as an inpatient.
  - **Skilled nursing facility** — At the time of the individual’s admission as a resident.
  - **Home health agency** — In advance of the individual coming under the care of the agency or at the time of the first home visit, as long as the information is furnished before care is provided.
Advance Directives — Provider Responsibilities (cont.)

- **Personal care services** — In advance of the individual coming under the care of the personal care services provider or at the time of the first home visit, as long as the information is furnished before care is provided.

- **Hospice program** — At the time of initial receipt of hospice care by the individual from the program.
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 Investigative Unit as follows:

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

First Choice VIP Care Plus 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.