Statin use in patients with diabetes

The Pharmacy Quality Alliance (PQA) has endorsed a new CMS display measure for 2017: the use of statins in diabetic members. This Medicare Part D measure calculates the percentage of patients between ages 40 and 75 who received at least two fills of diabetic medications and a statin during the same period. We would like to collaborate to improve this measure. You may receive calls specific to this measure for our members in your care, and, if so, a statin may be appropriate for that member. We offer several generic options on our formulary, so there are options to treat these members appropriately.

It's not always bad to be a quitter!

Quitting smoking is tough, but we are here to help our members. We understand the positive effects of quitting can be seen almost immediately. Within 12 hours of quitting, the carbon monoxide levels in the bloodstream return to normal. One year after quitting, the risk of heart disease is decreased to half of a smoker's risk. Five years after quitting, the risk of mouth, throat, and other cancers is also cut in half. Our plan covers both prescription and non-prescription options when it comes to quitting. Whether it is prescription medication like Chantix™, nicotine nasal spray, or even gum, we have our members covered. Let's help them quit together!

Charging for prescriptions

Did you know? Medicare does not allow doctors to charge for writing a prescription. A typical doctor's visit involves a review of medical history, discussion of a condition or symptom, examination, and/or treatment. A prescription is part of treatment and is included in the cost of the doctor's office visit.

Culturally and Linguistically Appropriate Services (CLAS)

Our plan works to provide culturally competent health care through its CLAS program. Several of the plans in our family of companies have been recognized for culturally competent care by the National Committee for Quality Assurance (NCQA). NCQA is the nation's most trusted independent source for driving health care quality improvement. The goal of our cultural competency program is to ensure all of our members, regardless of culture, country of origin, language, race, or ethnicity, are able to access quality health care services. We recognize that it is our responsibility, and our participating providers', to ensure health-related information and services are tailored to meet the unique needs of our diverse membership.

To earn this distinction, NCQA examines how we implement the 15 national CLAS standards, including race, ethnicity, and language data collection; access to and availability of language services; provider network cultural responsiveness; CLAS program; and work reducing health care disparities. We foster cultural awareness both in our staff and in our provider community by leveraging ethnicity and language data to ensure that the cultures prevalent in our membership are reflected to the greatest extent possible in our provider network. We routinely examine the access to care standards for both the general population and the population who speaks a threshold language, defined as a language spoken by at least 5 percent of our plan's population.

To support this effort, AmeriHealth VIP Care offers interpretation services at no cost for our members. Language Services Associates' (LSA) INTERPRETALK® program provides a fast and easy way to communicate with our limited English proficiency (LEP) members. LSA has interpreters in more than 200 languages available 24 hours a day, seven days a week.

Connecting with an interpreter

Call Member Services at **1-866-533-5490** (8 a.m. – 8 p.m.) to access this service at no cost to our members. After hours, contact the 24-Hour Nurse Call Line at **1-855-809-9199** to connect to an interpreter. Be prepared to:

- Provide the member's name.
- Provide the member's Medicare ID number.
- Provide the member's preferred language.
- Ask for a medical interpreter.

After you provide this information to our Member Services department or the Nurse Call Line, you will be connected to an interpreter. Explain the objective of the call to the interpreter and then proceed by speaking to the member in the first person. In addition to language services, we also provide free TTY/TDD services for our hearing-impaired members. To connect to a TTY/TDD operator, members may call **1-866-533-5490**.

As a participating provider, you must do your part by participating in annual cultural competency training. Below are some links to resources and trainings to help you achieve this requirement:

1. Video series: What is Health Equity, and Why Does it Matter? Found under Activities > Video Library at **www.ihi.org/education/ihiopenschool/Pages/default.aspx**.
2. United States Department of Health and Human Services (USDHHS) Office of Minority Health at **www.thinkculturalhealth.hhs.gov/Content/clas.asp**.
3. USDHHS Health Resources and Services Administration at **www.hrsa.gov/culturalcompetence/index.html**.

Just for fun

Find out where you are on the health literacy scale

Do your patients always go away completely understanding what you've told them and knowing exactly what to do next, or do you sometimes baffle them with science? Take the quiz to find out!

1. What is your first step when you are talking to someone about their health or medication?
   a) Find out what they already know.
   b) Make sure you have their name and address correct.
   c) Ask what is wrong with them.

2. Which of these are key steps for building people's health literacy?
   a) Link all new information back to what the person knows.
   b) Use the person's own words and build on them.
   c) Give information in logical steps.
   d) All of the above.

3. What is a good way to draw attention to key points in written material?
   a) Tear out the particular page and give it to them.
   b) Highlight the information in some way.
   c) Try to avoid giving people written information at all.

4. The best way to give people information is:
   a) Refer them to an appropriate website.
   b) In manageable chunks.
   c) All at once, so they get the whole picture.

5. Rather than overload people with too much information at one time:
   a) Give them a pamphlet.
   b) Ask them to make another appointment later.
   c) Agree with them on the best way to get more information.

6. A picture is worth:
   a) A thousand words.
   b) Not a lot, unless it includes explanatory words.
   c) Quite a bit if it is a Rembrandt.

7. When reinforcing information, you should (choose all that apply):
   a) Ask the person to give you a written summary of what you have told them.
   b) Check for understanding (ask them to tell you what they understood about what you said).
   c) Use pictures and diagrams.
   d) Link the information back to what the person knows.
   e) Use prompts, e.g., "Do you remember what we said about…"
   f) Bring in another health professional to discuss the same information with the person.

8. When checking with someone that you have been clear, you should use:
   a) Open-ended questions.
   b) Closed questions.

9. When reviewing medicines, you should (choose all that apply):
   a) Use the person's actual medicines.
   b) Find out what the person already knows about their medicines.
   c) Ask the person which medicine they want to start with.
   d) Consider using medicine cards.

10. People with low health literacy:
    a) Understand everything health professionals tell them.
    b) Are less likely to ask questions of their health professionals.
    c) Have fewer problems with their medicines than others.

ANSWERS:

1 — a 2 — d 3 — b 4 — b 5 — c 6 — a

7 — c 8 — a 9 — All of the above 10 — b

1 – 2 out of 10

There is definitely static on the line. Time to start using better techniques to help your patients build their health literacy.

3 – 4 of out of 10

Not the best, but you have potential. While you're on the right track, there is room for improvement.

5 – 6 out of 10

Not bad. You get the message across most of the time, but some patients might not be getting the full picture.

7 – 8 out of 10

Good performance. You're a great communicator, and with a few improvements, you'll be brilliant!

9 – 10 out of 10

Crystal clear with five-bar signal. Congratulations! You are an excellent communicator — clear and direct. Well done; keep up the good work and lead by example.

Source — www.hqsc.govt.nz.

June 15 — World Elder Abuse Awareness Day

The International Network for the Prevention of Elder Abuse and the World Health Organization at the United Nations (UN) annually observes World Elder Abuse Awareness Day (WEAAD) on June 15th. On that day, communities in the United States and all over the world sponsor events to highlight the growing tragic issue of elder abuse.

Every year, an estimated 5 million, or 1 in 10, older Americans are victims of elder abuse, neglect, or exploitation. And that's only part of the picture: experts believe that for every case of elder abuse or neglect reported, as many as 23.5 cases go unreported. Older adults are contributing members of American society, and their abuse or neglect diminishes all of us. America has confronted and addressed the issues of child abuse and domestic violence, but for too long we have ignored the issue of elder abuse.

Elder abuse can be physical, emotional, financial, and sexual. It includes people who are neglected and those who neglect themselves (self-neglect). Elders who are abused are twice as likely to be hospitalized, four times as likely to go into nursing homes, and three times as likely to die. While most abusers are family members, trusted professionals and complete strangers may also target older adults. Abuse can happen in any setting: in the older adult's own home, nursing homes, or assisted living facilities.

Alliances among local entities that have regular contact with older adults, such as aging services providers, health professionals, long-term care and nursing home staff, and law enforcement officers, can help improve the health, safety, and financial security of older adults. Consider starting an elder justice coalition or multidisciplinary team in your community as a way to launch WEAAD. This type of multidisciplinary effort can contribute richly to your community efforts to prevent and intervene in cases of elder abuse for years to come. Contact the National Center on Elder Abuse at **www.ncea.aoa.gov** for more information about starting or reinvigorating your own local elder justice community coalition.

Red flags of elder abuse:

Neglect

- Lack of basic hygiene, adequate food, or clean and appropriate clothing.
- Lack of medical aids (glasses, walker, dentures, hearing aid, and medications).
- Person with dementia left unsupervised.
- Person confined to bed left without care.
- Home cluttered, filthy, in disrepair, or having fire and safety hazards.
- Home without adequate facilities (stove, refrigerator, heat, cooling, working plumbing, and electricity).
- Untreated bedsores (pressure ulcers).

Financial abuse and exploitation

- Lack of amenities victim could afford.
- Vulnerable elder or adult "voluntarily" giving uncharacteristically excessive financial reimbursement or gifts for needed care and companionship.
- Caregiver having control of elder's money but failing to provide for elder's needs.
- Vulnerable elder or adult signing property transfers (power of attorney or new will) but being unable to comprehend the transaction or what it means.

Psychological and emotional abuse

- Unexplained or uncharacteristic changes in behavior, such as withdrawal from normal activities and unexplained changes in alertness.
- Caregiver isolating elder (not letting anyone come into the home or speak to the elder).
- Caregiver being verbally aggressive or demeaning, controlling, overly concerned about spending money, or uncaring.

Physical or sexual abuse

- Inadequately explained fractures, bruises, welts, cuts, sores, or burns.
- Unexplained sexually transmitted diseases.

Provider directory outreach

CMS has revised its requirements for Medicare plans' provider and pharmacy directories. The new requirements include conducting quarterly outreach to contracted providers to ensure the accuracy of all provider directory data, as well as collecting additional provider directory data from providers participating in dual eligible special needs plans.

To verify the accuracy of our directory data and to gather the additional information, we are furnishing each provider organization with a data sheet for the practice or facility along with one for each of the providers in the practice, if applicable. We will be sending these out quarterly and ask you to please review each data sheet and indicate any corrections which should be made directly on the sheets provided, such as address, phone number, hours of operation, missing data, or the addition or termination of a provider. In addition, please answer the questions pertaining to the additional data we are collecting. We will include information on where to return the completed data sheets. If we do not hear from you within 30 days, we will assume your information is correct.

Prohibition on balance billing qualified dual eligible members

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 processes to resolve any outstanding claims payment issues. Providers may reference CMS Medicare Learning Network® (MLN) Matters number SE1128 for further details.

Partner with us to prevent health care fraud, waste, and abuse

AmeriHealth VIP Care recognizes the importance of the detection, investigation, and prevention of fraud, waste, and abuse.

Our Fraud, Waste, and Abuse Program is dedicated to preventing any form of suspicious activity related to potential health care fraud, waste, and abuse. The program includes investigation of any reasonable belief that fraud, waste, and/or abuse may be, is being, or has been committed. If you become concerned about or identify potential fraud, waste, or abuse, we encourage you to contact us by:

- Calling us on our toll-free Fraud, Waste, and Abuse Hotline at **1-866-833-9718**.
- Emailing us at **fraudtip@amerihealthcaritas.com.**
- Writing to us at: Special Investigations Unit, AmeriHealth Caritas, 200 Stevens Drive, Philadelphia, PA 19113.

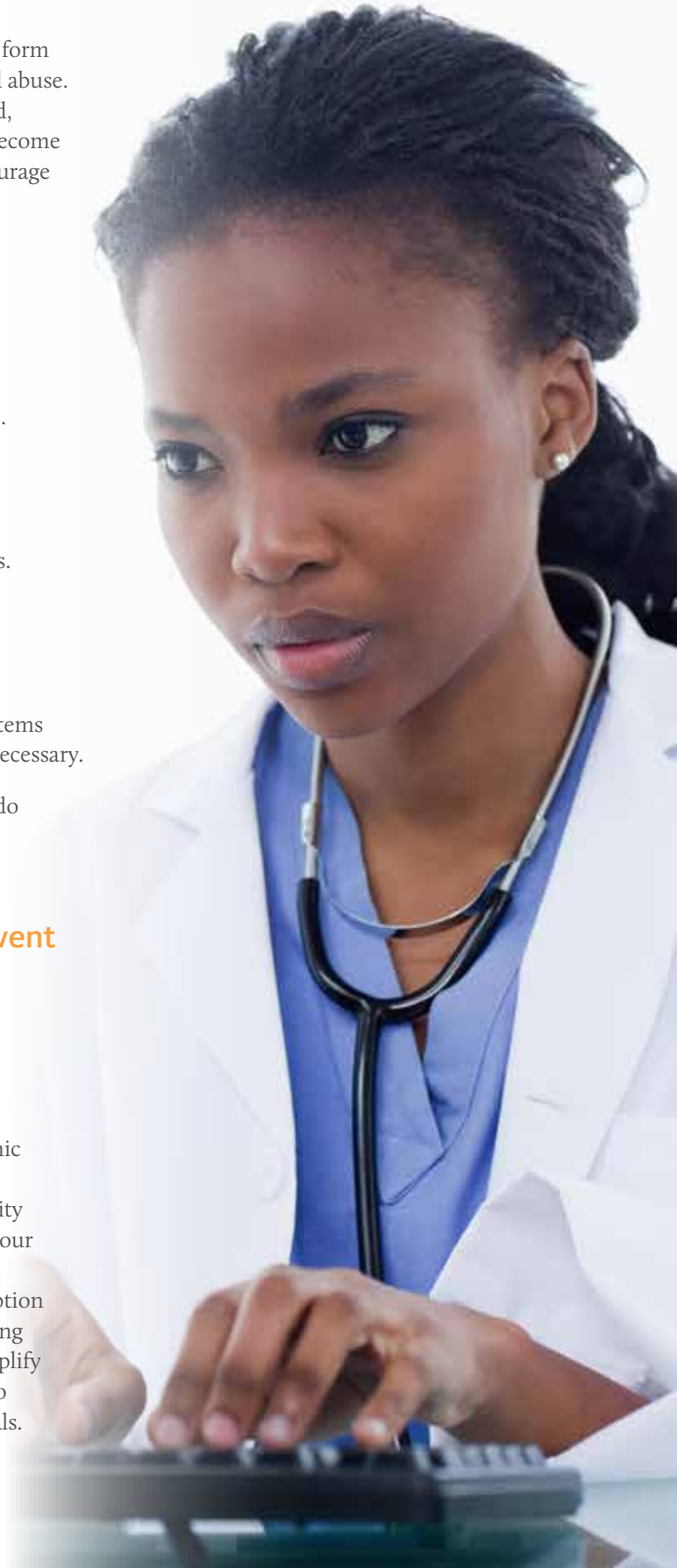
Some examples of fraud, waste, or abuse include:

- Billing for services not furnished.
- A member using another member's ID card to receive care.
- Submitting false information to obtain authorization to furnish services or items to Medicare and Medicaid recipients.
- Accepting kickbacks for patient referrals.
- Violating physician self-referral prohibitions.
- Billing for a more costly service than performed.
- Providing, referring, or prescribing services or items that are not medically necessary.
- Providing services that do not meet professionally recognized standards.

We look forward to partnering with you to prevent fraud, waste, and abuse.

Referrals

Providers were notified in January 2016 that AmeriHealth VIP Care would no longer require an official, plan-issued paper or electronic referral for members to access specialty care providers and services. This caused some confusion, and we would like to take this opportunity to clarify the notice. At this time, AmeriHealth VIP Care still requires our primary care providers to refer their patients for any needed specialist services. To make this process easier, in January 2016 we added the option of simply documenting the referral in the patient record and submitting the referring physician on the CMS 1500, which we hoped would simplify the process and reduce your administrative burden. This means we no longer require you to use our paper form or NaviNet to submit referrals.



Advanced beneficiary notices (ABNs) — Not for use with Medicare Advantage members

Per a CMS memo dated May 5, 2014, providers may not use an ABN with patients who are on a Medicare Advantage plan. Medicare Advantage plans must properly notify members regarding matters of non-coverage, and this is done through the prior authorization process. Circumventing this process diminishes member protections that are part of the prior authorization process. In circumstances where there is a question whether or not the plan will cover an item or service, the member has the right to request a prior authorization. If coverage is denied, the plan must provide the member with a standardized written denial notice that states the specific reasons for the denial and informs the member of his or her appeal rights. This means that the member is not liable for services provided by a contracted provider if the Medicare Advantage plan failed to provide a compliant denial notice. For more details on this requirement, please refer to chapter 4 of the "Medicare Managed Care Manual."

Emdeon change

Emdeon, the revenue and payment cycle management provider for our plan, has rebranded as Change Healthcare. Emdeon announced the change in September 2015. It has begun migration of its website, offices, and communications to the new brand. You will continue to have access to the important information you need. To help keep things simple, here are a few things that may help:

- Change Healthcare has not closed the existing Emdeon website. All existing Emdeon bookmarks will continue to work.
- The login button on the new (Change Healthcare) site will redirect you to legacy (Emdeon) sites and product lists.
- Contact Change Healthcare (Emdeon) at **1-877-363-3666** or visit **www.changehealthcare.com** and select **Resources** for:
  - Enrollment.
  - Product support.
  - Payer lists.
  - Electronic funds transfer (EFT)/e-payment.
  - Payer electronic remittance advice (ERA).

Over the coming months, Change Healthcare will continue to update the provider community about its new identity.

For more information on the rebrand, please visit **emdeon.mediaroom.com**. If you have questions, please contact your Provider Account Executive. You may also contact our Provider Services department at **1-800-521-6007**.

NaviNet has a new look

NaviNet has upgraded its Plan Central, Eligibility and Benefits, and Claims Status Inquiry transactions for easier navigation. You will see the following enhanced features:

Plan Central: Easily view the latest updates and get quick access to:

- Frequently asked questions.
- Hours of availability and contact information for the plan.
- Quick links to provider tools.

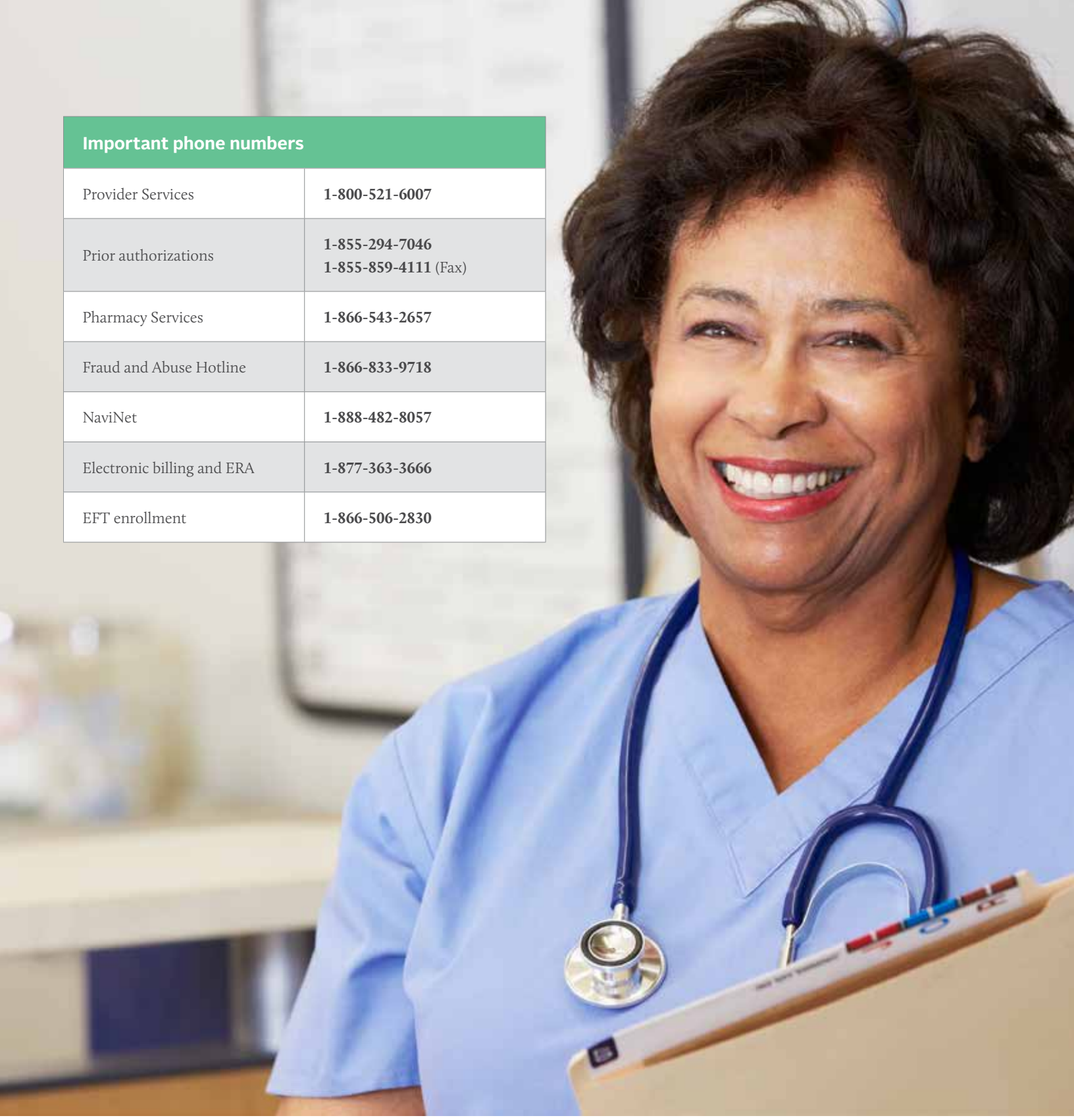
Eligibility and Benefits: View eligibility status and date, benefit information for different services, and patient details.

- **Screen header:** The patient's name, gender, and date of birth are displayed prominently at the top of the screen to confirm you are viewing details for the correct patient.
- **Patient details window:** You can view more details about the patient by choosing "View Patient Details" at the top of the screen. This link opens the patient details window, which displays patient demographic information and subscriber details.
- **Eligibility status bar:** The overall coverage status of the patient appears in large font for quick confirmation. The eligibility date (start date or range) is shown to the right of the eligibility status.
- **Services menu:** A list of services supported by the health plan is displayed. Services are listed alphabetically, and the currently selected service is always highlighted in the services menu. You can choose a service to see benefit details for the patient in the details section to the right of the menu.
- **Details section:** When you select a service in the services menu, the details section shows benefit details for the patient. The header displays the name of the service selected.

Claim Status Inquiry: Access real-time, detailed claim status information, which can eliminate the need to make phone inquiries. You can check claim status at any time following a claim submission, for all claims, regardless of submission method.

- **Screen header:** The patient's name and date of birth are displayed prominently at the top of the screen to confirm you are viewing details for the correct patient.
- **Claim status bar:** Current claim status, overall claim status, and status details are displayed.
- **Claims summary section:** The most important details of the claim, including the total charge from the provider and the amount paid by the health plan, are prominently displayed.
- **Service line details section:** Details of the individual claim service line are displayed.
- **Additional payment details:** The allowed amount, amount applied to member responsibility, and explanation of benefits description are displayed for each line item.

Questions? You can find additional information on NaviNet Plan Central in the "NaviNet Enhancements Training Guide," which gives you detailed previews of the new screens. As always, feel free to contact your Provider Account Executive with any questions.



Important phone numbers	
Provider Services	**1-800-521-6007**
Prior authorizations	**1-855-294-7046** **1-855-859-4111** (Fax)
Pharmacy Services	**1-866-543-2657**
Fraud and Abuse Hotline	**1-866-833-9718**
NaviNet	**1-888-482-8057**
Electronic billing and ERA	**1-877-363-3666**
EFT enrollment	**1-866-506-2830**

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AHVIPCPA-16503

www.amerihealthvipcare.com

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