# 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.

**Spring/Summer 2019**

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AmeriHealth Caritas VIP Care

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**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

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

1J.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.

2S. 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<br>**Z602** Problem related to living alone<br>**Z603** Acculturation difficulty<br>**Z604** Social exclusion and rejection<br>**Z605** Target of (perceived) adverse discrimination and persecution<br>**Z608** Other problems related to social environment<br>**Z609** Problem related to social environment, unspecified |
| **Upbringing** | **Z6221** Child in welfare custody<br>**Z6222** Institutional upbringing<br>**Z6229** Other upbringing away from parents<br>**Z62810** Personal history of physical and sexual abuse in childhood<br>**Z62811** Personal history of psychological abuse in childhood<br>**Z62812** Personal history of neglect in childhood<br>**Z62819** Personal history of unspecified abuse in childhood |
| **Family and social support issues** | **Z630** Problems in relationship with spouse or partner<br>**Z6331** Absence of family member due to military deployment<br>**Z6332** Other absence of family member<br>**Z634** Disappearance and death of family member<br>**Z635** Disruption of family by separation and divorce<br>**Z636** Dependent relative needing care at home<br>**Z6371** Stress on family due to return of family member from military deployment<br>**Z6372** Alcoholism and drug addiction in family<br>**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<br>**Z651** Imprisonment and other incarceration<br>**Z652** Problems related to release from prison<br>**Z653** Problems related to other legal circumstances<br>**Z654** Victim of crime and terrorism<br>**Z655** Exposure to disaster, war, and other hostilities |
| **Inadequate material resources** | **Z753** Unavailability and inaccessibility of health care facilities<br>**Z754** Unavailability and inaccessibility of other helping agencies |
| **Contact with and suspected exposure** | Z77010 Contact with and suspected exposure to arsenic<br>Z77011 Contact with and suspected exposure to lead<br>Z77090 Contact with and suspected exposure to asbestos<br>Z570 Occupational exposure to noise<br>Z571 Occupational exposure to radiation<br>Z572 Occupational exposure to dust<br>Z5731 Occupational exposure to environmental tobacco smoke<br>Z5739 Occupational exposure to other air contaminants<br>Z574 Occupational exposure to toxic agents in agriculture<br>Z575 Occupational exposure to toxic agents in other industries<br>Z578 Occupational exposure to other risk factors |
| **Stress** | Z733 Stress, not elsewhere classified<br>Z734 Inadequate social skills, not elsewhere classified<br>Z7389 Other problems related to life management difficulty<br>Z739 Problem related to life management difficulty, unspecified<br>Z658 Other specified problems related to psychosocial circumstances<br>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.

1George 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, AmeriHealth Caritas VIP Care 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 **1-800-521-6007**.

## 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.

**Current plan interventions to help improve HEDIS outcomes:**

- **Diabetes care —** Members with diabetes are offered in-home diabetic testing including HbA1C, urine, and eye imaging when approved by a treating provider.
- **Care for older adults (COA) —** Our plan can assist providers in completing these assessments:
  - ✓ Care management contacts members to complete COA assessments, including pain, advance directives, and functional status.
  - ✓ The Pharmacy department conducts COA medication reviews.
  - ✓ Documentation is sent to the member's primary care provider (PCP) for inclusion in the member records. The health plan relies on data in the medical record as evidence that a HEDIS requirement has been met.
- **Colorectal cancer screening —** We work with lab vendors to offer members in-home screening kits.
- **Breast cancer screening —** Member outreach campaigns assist members in scheduling mammograms.
- **Osteoporosis management —** Letters are sent to providers regarding members who are at high risk for falls.

- **Rheumatoid arthritis management —** Letters are sent to providers regarding members identified with rheumatoid arthritis who are not seeking treatment.
- **Medication adherence —** Plan pharmacists conduct utreach campaigns to assist members with medication adherence.
- **Member outreach campaigns:**
  - ✓ Phone messaging blasts — Flu and pneumonia vaccines and health screenings.
  - ✓ Postcard reminders — Flu and pneumonia vaccines and health screenings.
  - ✓ Health fairs offering flu vaccines and health screenings.
- **Provider quality score cards —** Sent to all PCPs who have members assigned to them.
- **Record collection —** Accessing internal member records to meet care gaps.

Please contact our Quality department by phone at **1-215-937-8115** or email at **vipquality@amerihealthcaritas.com** for details on HEDIS and other star ratings measure descriptions.

## What are CAHPS and HOS?

The CAHPS® program is a multiyear survey initiative to support and promote the assessment of consumers' experiences with health care providers and systems. These surveys cover topics important to consumers and focus on aspects of quality consumers are best qualified to assess, such as the providers' communication skills and the ease of access to health care services.

A random sample of health plan members is selected from eligible Medicare Advantage (MA) contracts to participate in the CAHPS program each year. Surveys are administered between March and June, beginning with surveys distributed by mail and concluding with telephone-assisted surveys for participants who have not responded. More details on the CAHPS survey and how it applies to Medicare Advantage plans can be found at **www.ma-pdpcahps.org**.

The **HOS** assesses the ability of a Medicare Advantage organization to maintain or improve the physical and mental health of its members over time. A random sample of health plan members is selected from eligible Medicare Advantage contracts to participate in the HOS program each year. Surveys are administered between April and July, beginning with surveys distributed by mail and concluding with telephone-assisted surveys for participants who have not responded. More details about HOS measures can be found at **www.hosonline.org**.

CAHPS and HOS ratings account for more than a quarter of overall CMS star quality ratings, but that is not the only reason AmeriHealth Caritas VIP Care cares. Improvements in quality ratings are an indication that AmeriHealth Caritas VIP Care members are enjoying healthier, happier, and more productive lives. Everyone deserves to live life fully, so please read through this brief guide to CAHPS and HOS.

- **Annual flu and pneumonia vaccines:** This measures the percent of sampled members who received an influenza vaccination since the prior July and the percent of sampled members who reported ever receiving a pneumococcal vaccine.
- **Obtaining needed care:** Members rate how often it was easy to get appointments with specialists and how often it was easy to get the care, tests, or treatment they needed through their health plan in the prior six months.
- **Getting appointments and care quickly:** Members rate how often in the previous six months they were able to schedule an appointment and get care as soon as they needed. Members also rate how often they saw the provider they came to see within 15 minutes of their appointment times.
- **Overall rating of health care quality:** On a zero-to-10 scale, members rate their health care in the previous six months.
- **Overall rating of plan:** On a zero-to-10 scale, members rate their health plan.
- **Coordination of care composite measure:** Members rate their providers' familiarity with their medical history and prescriptions, how well providers follow up with patients after tests, and how well their PCPs manage their care with specialists or other providers.
- **Obtaining medications:** Members rate how often in the last six months it was easy to use their health plan to get prescribed medicines, to fill a prescription at a local pharmacy, and to fill prescriptions by mail.
- **Improving or maintaining physical health:** Members report whether their physical health is the same or better than expected in the past two years.
- **Improving or maintaining mental health:** Members report whether their mental health is the same or better than expected in the past two years.
- **Monitoring physical activity:** Members report whether they have discussed exercise with their providers and if they were advised to start, increase, or maintain their physical activity level during the year.
- **Improving bladder control:** Members who report having a urine leakage problem are asked whether they have discussed it with their providers. Those who have are asked whether they received treatment for the problem.
- **Reducing the risk of falling:** Members who had a fall or problems with balance and discussed it with their providers are asked whether they received a fall-risk intervention in the last year.

## 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 AmeriHealth Caritas VIP Care members who are aligned with the AmeriHealth Caritas Pennsylvania Community HealthChoices (CHC) plan. If your office identifies a patient who is a member of our plan and AmeriHealth Caritas Pennsylvania CHC who you believe could benefit from these types of LTSS services, please contact our Care Management department at **1-855-859-4082** or the CHC Care Management department at **1-855-332-0116**.

## 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. AmeriHealth Caritas VIP Care would like to work with providers to find safer alternatives for our members over age 65. Please contact member Care Coordinators at **1-800-521-6007**, 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 training requirements

### Model of Care

AmeriHealth Caritas VIP Care's Model of Care is an integrated care management approach to health care delivery and coordination for individuals dual eligible for both Medicare and Medicaid. The Model of Care involves multiple disciplines coming together to provide input and expertise for a member's individualized plan of care. This plan is designed to maintain the member's health and encourage the member's involvement in their health care.

CMS requires providers who care for our members to participate in and attest to completing our annual Model of Care training. Annual Model of Care training is also a contractual requirement for all participating providers. This required training can be accessed in any of the following ways:

- Online via an interactive Model of Care training module on our website.
- In person from an AmeriHealth Caritas VIP Care Account Executive or at a training seminar. Training seminar information will be sent out when one is available in your area.
- Through printed Model of Care training materials available online or by calling your AmeriHealth Caritas VIP Care Account Executive.

Providers may find information on the Model of Care and the annual training requirement in the Provider Manual.

### Other 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

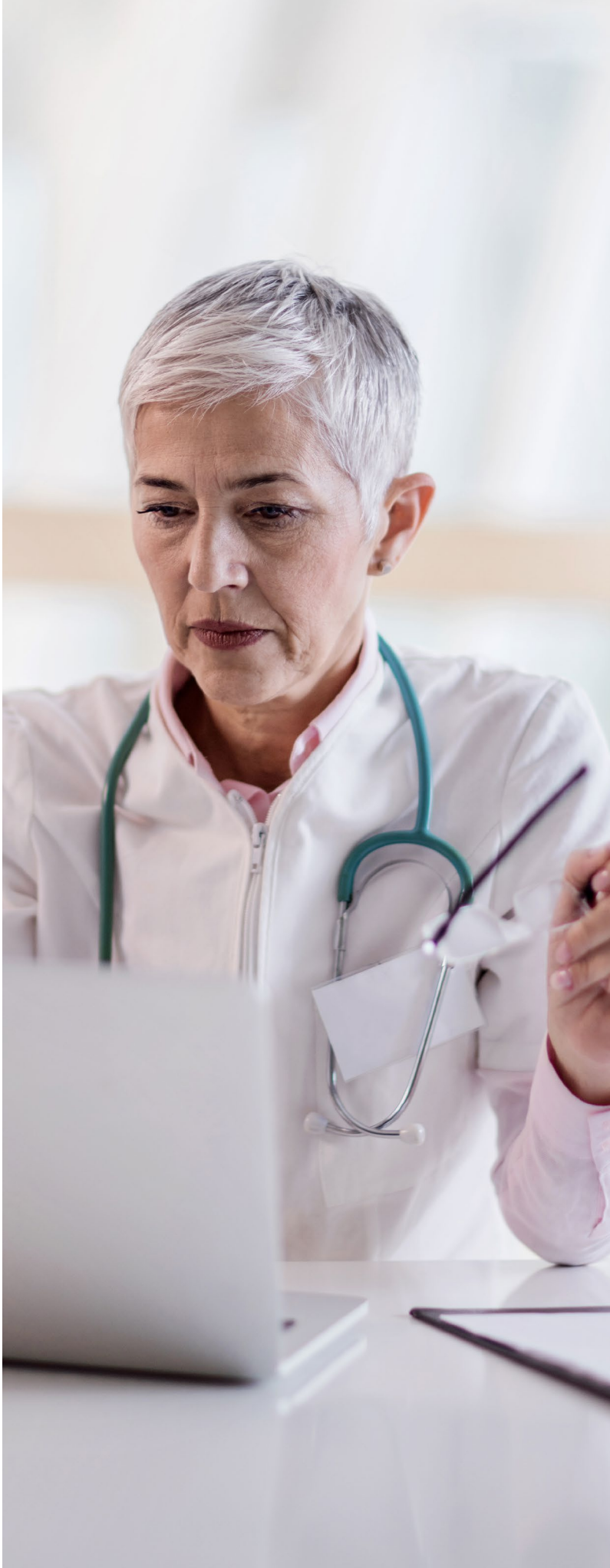
Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997, prohibits Medicare providers from balance billing qualified Medicare beneficiaries for Medicare cost-sharing. Under the requirements of the Social Security Act, all payments from our plan 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 abuse to AmeriHealth Caritas VIP Care

Providers who suspect an AmeriHealth Caritas VIP Care provider, associate, or member is committing fraud, waste, or abuse should notify the AmeriHealth Caritas VIP Care Special Investigations Unit as follows:

- By phone at **1-866-833-9718**.
- By mail at:
  AmeriHealth Caritas VIP Care
  Special Investigations Unit
  200 Stevens Drive
  Philadelphia, PA 19113

The AmeriHealth Caritas VIP Care 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 AmeriHealth Caritas VIP Care 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.**



## AmeriHealth Caritas VIP Care offers language interpretation assistance

AmeriHealth Caritas VIP Care serves a diverse population. As a result, providers may see patients who don't speak English or who have limited English proficiency. A small percentage of our members speak Spanish, Mandarin, Cantonese, Arabic, Vietnamese, and other languages. Our members may also need information provided in formats accessible to people with hearing and vision impairments. To help ensure information is accurately reported and understood, AmeriHealth Caritas VIP Care offers certified translation and interpretation services in more than 200 languages, as well as information in accessible formats.

These services include:

- Interpreting conversations with providers or health care staff.
- Translating health care plan documents.
- Getting plan documents in different formats.

For language assistance or alternative format documents, providers and members can call AmeriHealth Caritas VIP Care Provider Services at **1-800-521-6007.**

## Important phone numbers

Provider Services: **1-800-521-6007**

Prior authorizations: **1-855-294-7046**
**1-855-809-9202** (Fax)

Pharmacy Services: **1-866-828-0023**

Language Line: **1-800-521-6007**

- After hours: **1-888-765-6375**

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**

Coverage by AmeriHealth First.

**www.amerihealthcaritasvipcare.com**

# The Advantage

## A Newsletter for Providers

**Spring/Summer 2019**


AmeriHealth Caritas VIP Care

200 Stevens Drive
Philadelphia, PA 19113