# AmeriHealth Caritas VIP Care Plus

A MI Health Link Medicare Medicaid Plan

AmeriHealth Caritas
VIP Care Plus

# What is MI Health Link?

- A dual demonstration (pilot) program that joins Medicare and Medicaid benefits, rules and payments into **one** coordinated delivery system.
- It is a three-way agreement between CMS, MDCH and Integrated Care Organizations (ICOs).
- The ICOs hold sub-contracts with Pre-Paid Inpatient Health Plans (PIHP) for the behavioral health component.
- Operates in four regions in the state.

# Goals of the MI Health Link Program

Michigan is one of ten (10) states participating in this demonstration, which is an effort to address integrated care for people who are dually eligible with an aim to provide:

**Better care** by making it easier for dual eligible individuals to get all of their health care from a single Medicare-Medicaid Plan.

**Better value** through a care team and a care manager that works directly with the member and their doctors.

**Better health** through benefits that will help members stay healthy and live at home as long as possible.

# Who is eligible for the program?

## Eligible individuals are those who are:

- 21 and older
- Fully eligible for Medicare parts A, B, and D
- Fully eligible for Medicaid
- Live in the counties of Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, **Macomb**, St. Joseph, Van Buren, **Wayne**, or any county in the Upper Peninsula
  - ***AmeriHealth Caritas VIP Care Plus membership is limited to residents of Wayne and Macomb county***

## Individuals are ineligible if they are:

- Currently under Hospice care

# How many members are eligible for Michigan Health Link?

- The current estimates are that there are approximately 107,000 persons age 21 and older in these regions that are eligible to enroll in the program.
- With approximately 80,000 of those being in Wayne and Macomb counties.

# What makes this program different for members?

This program combines all of the benefits of Medicare (Parts A/B), Medicare Part D and Medicaid under a single Medicare-Medicaid Plan to make it easier to get the care they need. Members will continue to receive all the current services they receive under Medicare and Medicaid:

- ✓ Physician visits
- ✓ Hospital services
- ✓ Pharmacy
- ✓ DME

New benefits:

- ✓ One plan
- ✓ One card
- ✓ One phone number to call
- ✓ No insurance premiums
- ✓ No deductibles or copays for in-network services
- ✓ A care team
- ✓ An individualized care plan
- ✓ Help transitioning home from the hospital or nursing home

## What makes this program different for providers?

- Delivery system for Medicare and Medicaid covered services will work in unison rather than in silos.
- Simplified billing processes with the ICO as the single payer source.
- Person-centered planning, rather than a physician driven approach, is used in creating an individualized care plan, but will involve physician input.

# Enrollment Timelines

## MI Health Link Enrollment Timeline for Wayne and Macomb Counties:

| Marketing Began | April 1, 2015 |
|---|---|
| Initial Voluntary Opt In Effective Date | May 1, 2015 |
| Passive Enrollment Member Notification | 30 and 60 days prior to enrollment |
| Initial Passive Enrollment Effective Date | July 1, 2015 |
| Passive and voluntary Enrollment | Ongoing |

# Why AmeriHealth Caritas and Michigan Health Link?

- The AmeriHealth Caritas Family of Companies is a leader in providing health care solutions for the underserved and chronically ill.
- AmeriHealth Caritas is among the largest organizations of managed care plans and related businesses in the United States, touching the lives of more than 5.7 million individuals covered by Medicaid, Medicare, and other insurance.
- Our mission is, “We help people get care, stay well, and build healthy communities.”
- AmeriHealth Caritas VIP Care Plus is one of seven ICOs participating in this demonstration.

# AmeriHealth Caritas VIP Care Plus Service Area

AmeriHealth Caritas VIP Care Plus is an Integrated Care Organization for Wayne (Region 7) and Macomb (Region 9) counties.


AmeriHealth Caritas
VIP Care Plus

Other regions:

Region 1 – Upper Peninsula

Region 4 - Southwest

# Provider Resources

AmeriHealth Caritas
VIP Care Plus

# AmeriHealth Caritas VIP Care Plus Website

# Website Highlights

Available resources on the website:

- Provider Manual
- Searchable Provider Directory
- Searchable Drug Formulary
- Training Modules
- Provider Communications
- Forms
- Provider Reference Guide
- Link to NaviNet
- And much more…

www.amerihealthcaritasvipcareplus.com

# NaviNet Provider Portal Highlights

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

Through NaviNet providers can:

- Check claim status
- Print copies of remittances
- Check member eligibility
- Enter authorization requests
- Generate reports – Care Gaps, Clinical Summaries

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

# Provider Services Highlights

Provider Services can assist you with:

- Member eligibility
- Benefit inquiries
- Claims status
- Member concerns/resources

Provider Services is available seven days a week from 8:00 a.m. – 8:00 p.m. by calling 1-888-667-0318.

# Model of Care (MOC)

AmeriHealth Caritas
VIP Care Plus

# Model of Care Annual Training Requirement

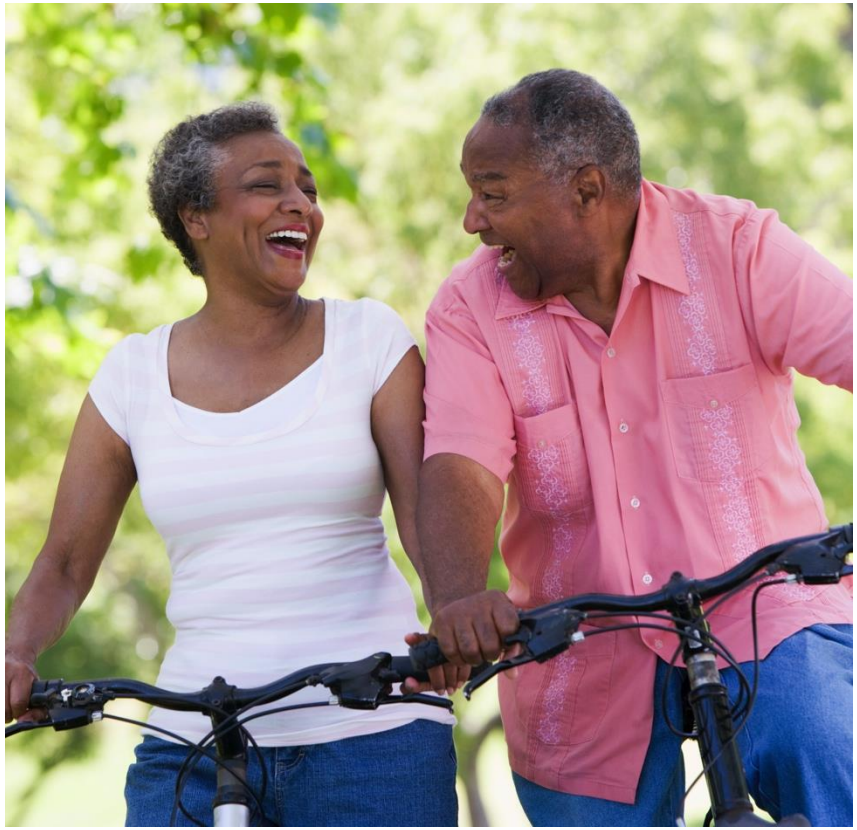
As a Medicare-Medicaid Plan, AmeriHealth Caritas VIP Care Plus is required to train its providers on how we integrate and coordinate care and services for our members. This is done through our Model of Care.

Providers may receive training on the Model of Care in the following ways:

- Access an online interactive Model of Care training module on our website, www.amerihealthcaritasvipcareplus.com, under the Provider Training and Education link - also available in PDF format
- Review printed Model of Care training materials received from the plan
- In person from a training seminar or a Network Management Account Executive

# Why was AmeriHealth Caritas VIP Care Plus Was Created?

The AmeriHealth Caritas VIP Care Plus plan was created to offer Medicare and Medicaid eligible beneficiaries the opportunity to receive coordinated benefits and efficiently and effectively manage their care.



The goals of creating this plan are:

- Improve health outcomes, while reducing health care expenditures
- Keep beneficiaries in the community
- Simplify the delivery system and align payment for the provider

**How is this accomplished?**

**Through the Model of Care.**

# What Is the Model of Care?

The Model of Care is:

- A high quality, patient centric medical care delivery system for dual eligible Medicare-Medicaid members.
- An approach of bringing multiple disciplines together as a team to provide input and expertise for a member's individualized care plan.
- Part of a plan designed to maintain the member's health and encourage member's involvement in their health care.

# What Is the Model of Care? – Simplified

The Model of Care is AmeriHealth Caritas VIP Care Plus's **Model of** how we **Care** for our Dual Eligible members.

# Why is the Model of Care Necessary?

Due to their greater health needs and utilization of services, dual eligibles are a high-cost population:

- There are approximately 9 million dual eligibles in the United States.
- They are more sick and frail than the general Medicare population.
- 21% of Medicare population = 31% of Medicare costs
- 15% of Medicaid population = 39% of Medicaid costs

Reference: https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8353.pdf

# How are Medicare-Medicaid (Dual Eligibles) Different from General Medicare Population?

They are:

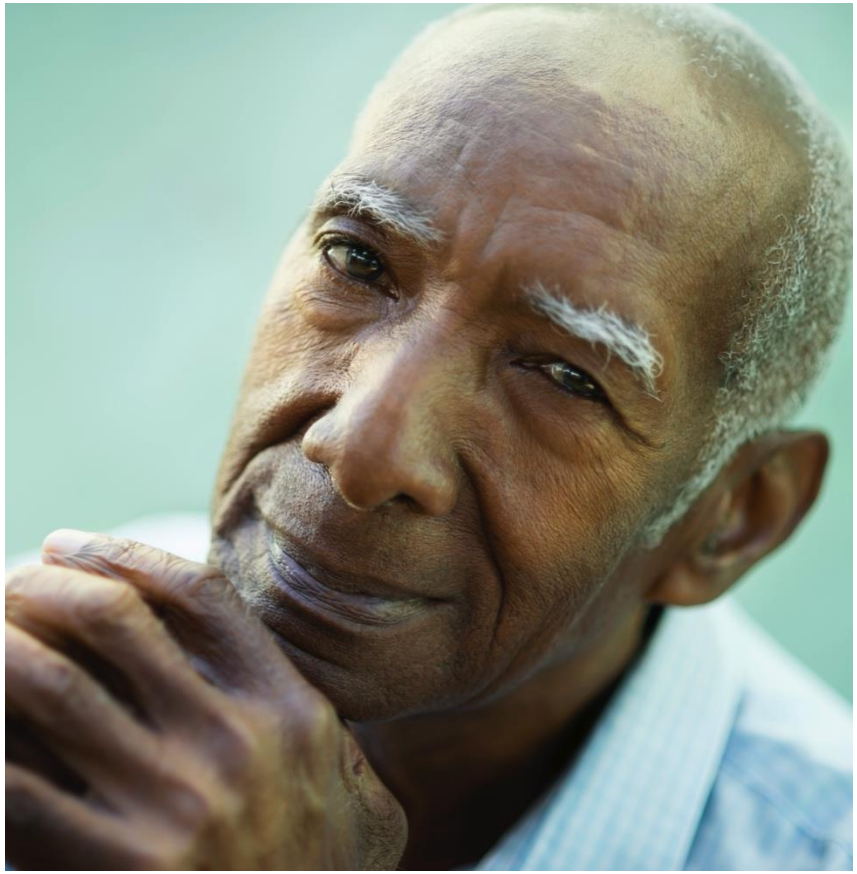
- Three times more likely to live with a disabling condition.
- More likely to have greater limitations in activities of daily living (ADLs), such as bathing and dressing.
- More likely to suffer from cognitive impairment and mental disorders.
- Indicated to have higher rates of pulmonary disease, diabetes,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

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

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

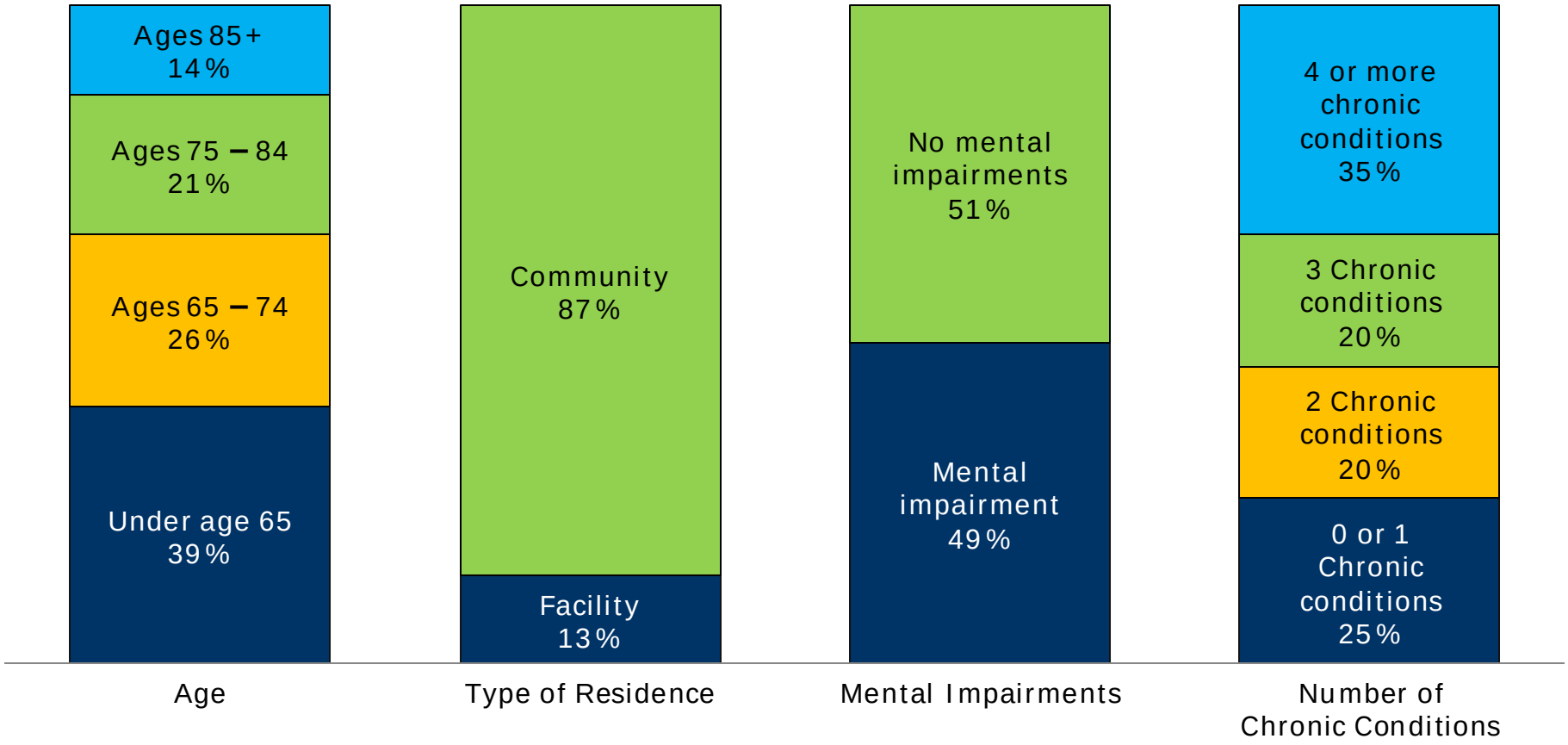
Issues in the dual-eligible population that increase costs include:

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



The AmeriHealth Caritas VIP Care Plus Model of Care aims to reduce healthcare expenditures and over utilization by providing coordinated care management for each AmeriHealth Caritas VIP Care Plus member.

# Why Are Dual Eligibles Special-Needs Members?




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

# Building the Model of Care Integrated Care Team (ITC)

An integral part of the MOC is building an ITC. This begins with the development of an AmeriHealth Caritas VIP Care Plus Care Team. Both the providers and members have access to this team which helps members modify their behavior and how they access health care.

The AmeriHealth Caritas VIP Care Plus Care Team includes:

- ✓ Personal Care Connectors
- ✓ Community Health Navigators
- ✓ Care Coordinators

# AmeriHealth Caritas VIP Care Plus Care Team Roles & Responsibilities

Personal Care Connectors I

All Customer Service Functions

Welcome Calls

Provider Lookup / PCP Assignments

Quoting Benefits

Initial Health Screening

General Appointment Assistance

Medicaid Re-Certification

Triage to Model of Care

Non-Clinical Call Campaigns

Gaps in care reminders

Community Health Navigator

In-person engagement

Links member to health and social service system

Assists with basic navigation such as shopping and transportation

Accompanies member to key appointments

Coaches for behavior change and condition management

Care Coordinator

In-Home Assessments

Develops plan of care

Member Care Team Leader

Local PCP Outreach

Transition Coordinator

Work together to support the member

# How does the Care Team Help Members?

**AmeriHealth Caritas VIP Care Plus Care Team understands the most common diagnosis is poverty.**

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

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

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

**The Care Team knows that caregiver involvement is critical.**

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

# Person-Centered Planning Approach

- ✓ The Care Team takes a person-centered planning approach with our members.
- ✓ Person-centered care begins with the individual's goals and respects and addresses their preferences and needs.
- ✓ While person-centered care planning places the individual at the center of WHAT care is to be provided, by WHOM and WHEN, the care manager is often at the center of HOW that care is coordinated.

# Person-Centered Planning Approach

Health and medical goals are highly individual and people's engagement in setting goals has been demonstrated to affect not only their participation in and adherence to treatment, but their health outcomes and quality of life. Care coordinators work with members to:

- **Step 1: Elicit Goals** – Identify what is important.
- **Step 2: Negotiate Goals** – Break goals down to smaller attainable goals, facilitate conversations.
- **Step 3: Support Goal Attainment** – Recognizing and addressing barriers, Motivational Interviewing.
- **Step 4: Monitor Goal Attainment** – Assessments and care plan updates.

# Continuing to Build the Model of Care Integrated Care Team (ITC)

**The Care Team alone cannot help the member reach their goals of the person-centered planning approach. The ITC is crafted to serve the individual goals/needs of each member and is completed by including the AmeriHealth Caritas VIP Care Plus Care Team along with the following, if applicable:**

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

# What is the Primary Care Provider/Medical Home's Role?

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

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

# How will the Integrated Care Team work together?

Collaboration between the care team care coordinator, the member, and the rest of Integrated Care Team, yields a ***Member Individual Care Plan*** that is specifically designed to meet the member's health and personal needs.

The team will be in charge of coordinating the needed services. For example:

- The care team will make sure the doctors know about all medicines a member takes so they can reduce any side effects.
- The care team will make sure a member's test results are shared with all of the member's doctors and other providers.
- Primary Care Physicians will be responsible for directing the member's care.
- The development and any updates needed to the Individual Care Plan (ICP).
- Manages medical, cognitive and psychosocial needs of member.
- Works together as a "team" to ensure best outcomes for the member.

# Member Care Plan

AmeriHealth Caritas VIP Care Plus | MI HEALTH LINK Linking Medicare & Medicaid for you

## Member Care Plan

| | | | |
|---|---|---|---|
| Member | Scott Calvin | Care Manager | zeuser |
| Member ID | 2836180 | Care Manager Phone | |
| Date of Birth | 11/01/2012 | Care Manager Email | |
| Eligibility Start Date | 08/01/2014 | Plan Last Updated | 11/17/2014 |

| Problem | Goal | Intervention and Status | Start/Completed Date |
|---|---|---|---|
| Alteration in Mental status changes r/t seizures | Member/Caregiver will be compliant with medication regime by obtaining, taking medication as prescribed | Assess member/caregiver knowledge on medications, purpose, side effects<br>Assess member medication compliance and educate as needed | 12/08/2014 / 01/01/0001 |
| Impaired physical mobility | Member will be able to state his/her physical limitation as it relates to disease process. | Assess for waiver services<br>Assess for knowledge regarding injury and rehabilitation.<br>Arrange for member/caregiver education regarding adaptive devices. | 12/08/2014 / 01/01/0001 |
| Ineffective Coping | Demonstrate effective coping mechanisms, setting up realistic goals, and positive adjustments to change in body image. | Assist client in identifying individual strengths | 12/08/2014 / 01/01/0001 |

# Model of Care — Plan Implementation Overview

1. Each member enrolls with a primary care provider/medical home.
2. An Initial Health Screen is completed upon enrollment.
3. A Comprehensive Assessment will be completed within 60 days of enrollment for all members. Level One and Level Two Assessments are used to collect member information regarding:

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

4. Care Team coordinates and arranges care for the member as needed.
5. An Individualized Care Plan is developed, which includes care and support from health care providers, community agencies and service organizations.

# Integrated Care Bridge overview

## What is the Integrated Care Bridge (ICB)?

- A web-based care coordination platform that is accessible for members and providers that allows secure access to the member's care plan.
- Allows all members and participants of the Integrated Care Team (ICT) to access and update information when appropriate.
- Providers can access the ICB through the NaviNet portal and members may access the ICB through the Member portal, both which are accessible on the AmeriHealth Caritas VIP Plus website.

We have had many member success stories due to the Model of Care process.

We would like to share some of those with you so you can see the impact we are having.

# Success Stories

# Success Story – Nursing Facility Transition Services

Member was hospitalized and admitted to inpatient rehab for muscle weakness and pain. The member's discharge plan was to return home to live with her family again. During her time at the nursing facility, her mobility decreased, she was not ambulatory and required a 2-person Hoyer lift for transfers.

The Care Coordinator and the member made arrangements for a member-centered planning meeting with the nursing facility staff, the member and her interested parties, the ICO Manager as well as the ICO Medical Director to discuss the member's desires and wishes for discharge and what needed to be in place to meet those discharge goals.

Through that meeting, her fiancé agreed to provide informal support, the granddaughter agreed to be a formal support, and 1 additional formal support from a vendor would provide additional supports for transfers. Through these 3 supports, the member would receive 3+ intervals of care and support each day. Additional services provided include Skilled Care (Nursing, PT and OT), DME (bed pan, bedside table, gel mattress pad, incontinence supplies, bedside commode, walker, bariatric hospital bed and lift chair). The member was also approved for wavier services and connected with a visiting physician. The member was discharged home to her family and reports that she was thrilled to be home for the summer.

# Success Story – Finding a Hard to Reach Member

A 69 year-old male member who was effective with our plan on 9/1/15, was determined to be "unable to locate". On 10/5/15, the member was found unresponsive covered in feces and urine by EMS and was admitted to the hospital. His family indicated he had been missing since June of 2015. The member has a history of Schizophrenia and Methadone use. Member also had diagnoses of decubitus ulcer, arthritis, liver disease, hypertension, kidney failure, sepsis, and asthma. Member was transitioned to a nursing facility for rehabilitative services.

During this time, our Care Coordinator (CC) worked with the member and the social worker at the nursing facility to make sure his needs were met. The member expressed interest in returning to the community to live, but the boarding house he lived in for 10 years had closed up and he knew he had a long road to recovery before he could live on his own again. After several years of recovery and with the assistance of the CC in finding him housing and some personal care services, the member was able to move into an apartment on 2/15/18 to live independently again.

# Success Story – Finding Extra Help for Members

- Member is an 80-year-old Polish woman that does not speak English. Member is receiving personal care services, non-emergency transportation, and Personal Emergency Response System (PERS). The member's daughter said that the services have been invaluable to their family because they have improved her mother's quality of life and independence. She said that her mom has a Polish-speaking caregiver that was assigned by the AAA. They are pleased with the AAA's vendor selection and ability to accommodate her mother's needs, especially her language. Family relationships have improved as the daughter can now be a daughter and not always a caregiver.

- Member was discussed in Interdisciplinary Care Team meeting, which included a representative from the local AAA, since she was to be discharged from a SNF. A CC and the AAA representative went to member's home on the day of discharge to complete a Level 2 assessment along with a transition of care assessment. The services that were recommended were PERS and personal care services. The member had to be readmitted to the hospital because when she was reaching for her walker in the bathroom she fell and hit her head. She was able to press the PERS button to receive assistance. Her son says that if she did not have that PERS, she would have been lying there alone for a very long time. He is very grateful for assistance and the service.

# Success Story – Finding Extra Help for Members

A member called into Member Services at 5:29 pm on a Friday stating that they were out of colostomy bags and would have nothing to carry them over the weekend. The DME provider was awaiting chart notes from the PCP's office (who was closed for the day). The Personal Care Connector (PCC) realized how urgent this situation was and, instead of leaving the traditional message for the office to follow up with member on Monday or putting the work off on another department, she consulted her lead and they sprang into action.

The lead agent called her manager's cell phone and the other PCC had the DME provider on another phone. Together they were all were able to come up with a temporary solution for the member. The manager gave authorization for the DME provider to supply one emergency bag with the promise that a Community Health Navigator (CHN) would go and personally have the records faxed to the DME provider on Monday. The member was able to secure supplies the same day. Although the PCCs were scheduled to leave at 5:30, they stayed until the job was complete. The member was so very grateful for the two PCCs not just "pushing them to the side".

On Monday morning, a CHN was assigned to work with member and the DME provider on a non-temporary solution. The CHN faxed records to the DME provider on Monday and made sure they received it. The CHN also ensured that the member obtained the needed supplies. The member was very relieved to have the supplies needed and pleased with timeliness of our response.

# Success Story – Behavioral Health / Community Resources

Words from a member's mother:

As I sit thinking of the past 7 months, I must share our success story. My son (our member) was born with something called Symbrachydactly (missing joints in his fingers and toes). Since birth, I advocated for services at school and home many times, unsuccessfully. Most professionals viewed my son as lazy, not understanding his condition. He has been involved in many State programs and provided a social worker, who was nice and friendly; but, he still fell in-between the cracks.

When we received the card in the mail indicating we were selected for this Pilot Program, my son was nervous, as he isn't comfortable with change. After many discussions and going back and forth with the previous State program, I convinced him to give it a chance.

For years, my son and I have been frustrated with the lack of assistance we received to help him adjust and maintain a normal life. At one point, he tried to commit suicide. He stopped bathing and taking his meds, which caused him to be hospitalized monthly. He just gave up on life. In my opinion, most of it had to do with his sister and I suffering from an auto accident. Her back was fractured. Both my legs broke, two pieces in my spine, and my left foot shattered in more than 100 pieces. His words were "what would happen to me if you died". So, he sent a text message to his sister, myself and his favorite cousin saying "I'm sorry for being a burden, I love you and goodbye". Thank heavens whatever he tried was unsuccessful. So, he pushed through; but, my concern is what would happen to my son if something happened to me?

# Success Story – Behavioral Health / Community Resources cont.

In September 2016, we had the initial evaluation with the Care Team. My son was still uncertain. However, the Care Team seemed to understand his needs, listened to his concerns, and cared about his overall wellbeing. My son believes he isn't considered a number on a caseload. After every phone call and visit, we stepped away feeling respected and treated with dignity. My son stated as a disable person he doesn't want folks to look at him with pity.

Since his enrollment into the Program, his seizures and hair loss have decreased. He hasn't had issues with filling his medicine. He has a girlfriend who is actually his best friend. This was an issue in the past because no one would take the chance on dating him due to his health issues. He will start school in the fall of 2017 to start his GED classes. Last year, his doctor shared news with us that if my son does have brain surgery he could die. After soaking in those words, my son stated he would start living life to the fullest.

I can't express how much this program not only saved his life but mine as well. With my own health issues and having 12 surgeries, I suffered from depression. Trying to meet his needs, along with mine, has been hard. I couldn't leave the house without him because at any moment he could have a seizure. I transport him to every appointment, sport practice, social event, clothing shopping, etc. My social life suffered due to his many health issues. He was issued a GPS monitor, equipment to assist with bathing, and more supplies are being ordered. My son is smiling again. He cares about his health. He takes his meds as prescribed. His eating is poor, but we're working with him to eating more veggies. **I'm forever grateful to this program and all the workers involved. This program saved our lives. Thank you the bottom of our hearts to the many people who work towards helping families and giving me my son back.**

# Continuity of Care Provision

AmeriHealth Caritas
VIP Care Plus

# Continuity of Care

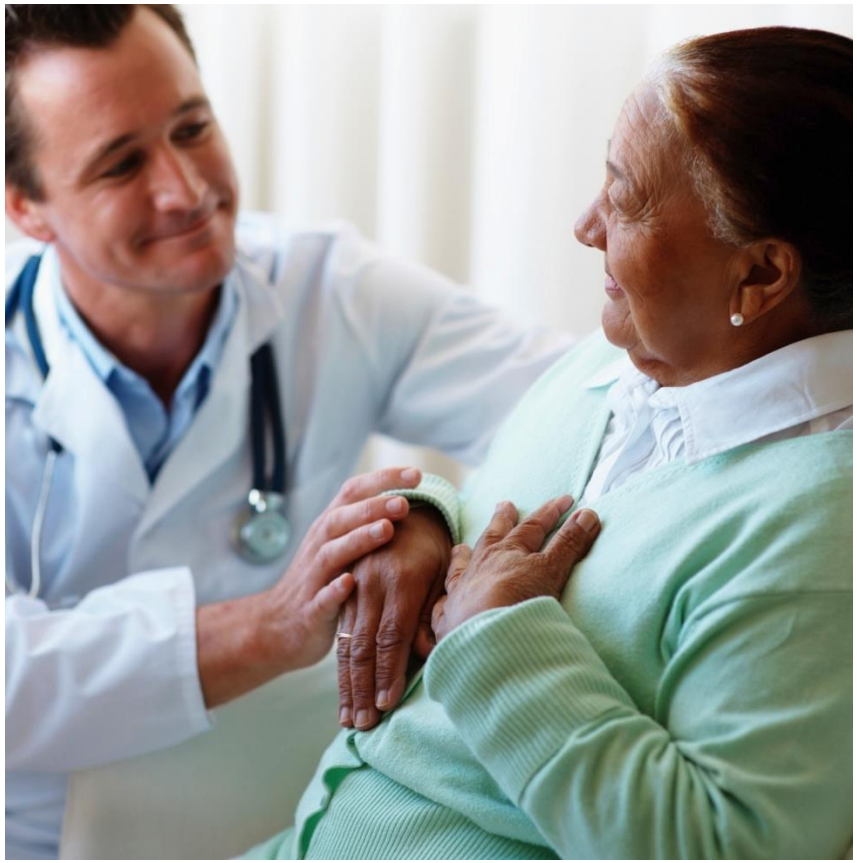
This program has been designed to provide dual eligibles with coordination of their care, including long term care needs.

- CMS wants providers to know that patients have a choice in what health plan they wish to join, and providers should not influence or try to tell them to leave a Medicare-Medicaid Plan (MMP) or Michigan Health Link.
- Given the vulnerability of this member population, AmeriHealth Caritas VIP Care Plus plan is required to offer a 180-day transition period for all members.
- Members will be allowed to maintain their current course of treatment with providers who are outside of our network. The 180-day transition period begins at the member's effective date.

# Continuity of Care

All of the member's providers are covered during this transition period:

- Primary Care Physicians
- Specialists
- Behavioral Health
- Long Term Services and Supports (LTSS)
- Pharmacy



# Single Case Agreements

AmeriHealth Caritas VIP Care Plus will make all efforts to contract with the providers who are currently not in our network, but are treating our members. However, if the provider elects not to contract with our network, AmeriHealth Caritas VIP Care Plus may offer providers single case agreements to continue a member's care after the 180-day transition period ends.

# Benefits

AmeriHealth Caritas
VIP Care Plus

# AmeriHealth Caritas VIP Care PLUS covers all

## Original Medicare and Michigan Medicaid Medical Benefits

- Medicare Parts A and B benefits
- Medicare Part D prescription drug benefits
- Michigan Medicaid benefits
- Long Term Services and Supports (LTSS) benefits
- Supplemental benefits

AmeriHealth Caritas VIP Care Plus **does not** charge deductible, coinsurance, or a copayment for Original Medicare and Michigan Medicaid medical benefits to the member. No premiums are paid by the member for these benefits.

# Benefits – Medicare vs. Medicaid: Which Program Pays for What Service?

| PLAN NAME | MEDICARE PARTS A & B | MEDICARE PART D | MICHIGAN MEDICAID |
|---|---|---|---|
| **Medicaid**<br>Michigan Department of Health and Human Services | NA | NA | ✓ |
| **Medicare Fee for Service or Medicare Advantage (MAPD)** | ✓ | ✓ | Not applicable for non-dual Medicare beneficiaries<br>FFS for dual eligible beneficiaries |
| **AmeriHeatlh Caritas VIP Care Plus**<br>Medicare Medicaid Plan | ✓ | ✓ | ✓ |

# Benefits – Medicare Part A and B Benefits* **

- Ambulance Services
- Cardiac and Pulmonary Rehabilitation Services
- Catastrophic Coverage
- Chiropractic Care
- Dental Services
- Diabetes Program and Supplies
- Diagnostic Tests, X-Rays, Lab Services, and Radiology Services
- Doctor Office Visits
- Durable Medical Equipment
- Emergency Care
- Hearing Services
- Home Health Care
- Hospice - Initial Consultation
- Inpatient Hospital Care
- Inpatient Mental Health Care
- Out-of Network Catastrophic Coverage
- Out-of-Network Initial Coverage
- Outpatient Mental Health Care
- Outpatient Rehabilitation
- Outpatient Services/Surgery
- Outpatient Substance Abuse Care
- Pharmacy
- LTC Pharmacy
- Mail Order Prescriptions
- Out-of-Network Catastrophic Prescriptions
- Outpatient Prescription Drugs
- Podiatry
- Preventive Services and Wellness/ Education
- Prosthetic Devices
- Skilled Nursing Facility
- Urgent Care

*Exceptions may apply, see provider manual for full list of benefits.

**Prior authorization may be required.

# Benefits – Medicaid Benefits

- Dental Services
- Durable Medical Equipment
- Family Planning Services
- Home Health
- Home and Community Based Services
- Medical Services
- Non Emergency Medical Transportation
- Nursing Facility Care
- Pharmacy Services (Tier 3)
- Prosthetics
- Sexually transmitted infections screening and counseling
- Vision care

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

# Carved Out Medicare Benefit

**Supplemental Benefits:**

- Meal benefit – Limited to 2 meals/day with authorization
- Fitness benefit through Silver Sneakers program
- Mail order over the counter medications and supplies
- Telemedicine
- 24/7 nurse hotline
- Free language translation line

**Covered by Medicare Fee for Service:**

- Hospice Services
- Behavioral Health (PIHP)

# Long Term Services and Supports (LTSS) Benefits

AmeriHealth Caritas
VIP Care Plus

# What are Long Term Services and Supports (LTSS)?

- Long Term Services and Supports (LTSS) are services and supports for persons with chronic illnesses/functional limitations which have the primary purpose of supporting the person's ability to live or work in the setting of his/her choice.

  Examples include:
  - Assistance with bathing
  - Assistance with dressing and other basic activities of daily life
  - Support for everyday tasks such as laundry, shopping, and transportation

- Managed Long Term Services and Supports (MLTSS) refers to the delivery of long term services and supports through capitated Medicaid managed care programs.
- Increasing numbers of states are using MLTSS as a strategy for expanding home- and community-based services, promoting community inclusion, ensuring quality and increasing efficiency.

# What are Medicaid Waivers?

Waivers are state specific Medicaid programs that allow for the Long Term Services and Supports to be provided outside of nursing homes. Waivers are also referred to as:

- 1915 waivers (for the Social Security Act)
- Home and community based services (HCBS) waivers
- Waiver services
- Waiver programs
- And by any number of other state-specific names

# History of the Waiver Program – Shaped by a Movement

## Katie Beckett and her parents - 1983

# Who Is Katie Beckett?

She is the child who inspired the waiver programs.

- 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 picked up, but would only cover services within the hospital.
- Her parents wanted her home and the doctors agreed.
- Federal officials refused to make an exception, but Ronald Reagan was told about the family and he changed the Medicaid rules.
- Katie was able to go home and, despite the odds, lived to age 34 due in part to being able to live a pretty normal life at home.

## Birth of the Waiver Programs

The name waiver comes from the fact that the federal government "waives" Medical Assistance/ Medicaid rules for institutional care to allow for states to use the same funds to provide these supports and services for people in their homes or in their own communities.

# LTSS/HCBS Services Include::

- Adaptive and assistive device services
- Adult day health
- Assisted living service
- Choices -home care attendant service
- Chore services
- Community transition service
- Emergency response service
- Enhanced community living
- Home care attendant
- Home delivered meals
- Home medical equipment and supplies
- Home modification, maintenance and repair
- Homemaker
- Independent living assistance
- Non Medical transportation
- Nursing service
- Nutritional consultation
- Personal care
- Pest control
- Respite
- Social work counseling

AmeriHealth Caritas VIP Care Plus also provides coverage for Nursing Home Custodial Room and Board service as needed for its members.

## Identifying Patients with These Needs

If your office identifies a patient who is a member of AmeriHealth Caritas VIP Care Plus that you believe can benefit from these types of long term service and supports, please contact our Care Management Department at 1-866-263-9181.

# Other Benefits

- Some waiver-like services can be offered as a supplemental benefit to non-waiver enrollees who have plan authorization.
- Free language service.
- If members are unable to reach their PCP office, registered nurses are available 24/7 to assist members through the toll-free Nurse Call Line:
  - AmeriHealth Caritas VIP Care Plus Nurse Call Line: 1-855-843-1145.
  - Please encourage our members to take advantage of this option.

AmeriHealth Caritas VIP Care Plus will refer members to local resources for services that are not covered by AmeriHealth Caritas VIP Care Plus, such as supportive, affordable housing and other social services that maximize community integration, as appropriate. Providers may contact AmeriHealth Caritas VIP Care Plus Provider Services at 1-888-667-0318 for assistance with coordination of non-covered services.

# Non-covered Benefits / Services

# Member Eligibility

AmeriHealth Caritas
VIP Care Plus

# Member Eligibility – Helpful Tips

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

- AmeriHealth Caritas VIP Care Plus covers both traditional Medicare and Michigan Medicaid Services.
- MI Health Link members can change plans each month.
- Verify eligibility before each visit.
  - Ensure member is seeing the appropriate provider.
  - Ensure that plan requirements are met. (Prior Authorizations)
  - Reduce claim issues because you are sending claim to the right plan.
- Make sure the the correct primary care physician (PCP) is listed on the member's identification card.
- Call Provider Services at 1-888-667-0318 with any questions.

# Member Eligibility – Ways to Verify Member Eligibility

Providers can verify members' eligibility by using the following provider resources:

- Calling Provider Services at 1-888-667-0318.
- NaviNet.
- Using the Member Identification Card. **However, a member's ID card is not a guarantee of eligibility.**

# Member Eligibility – How Can Members Enroll?

Individuals who want to enroll in one of the MI Health Link plans should contact Michigan ENROLLS at:

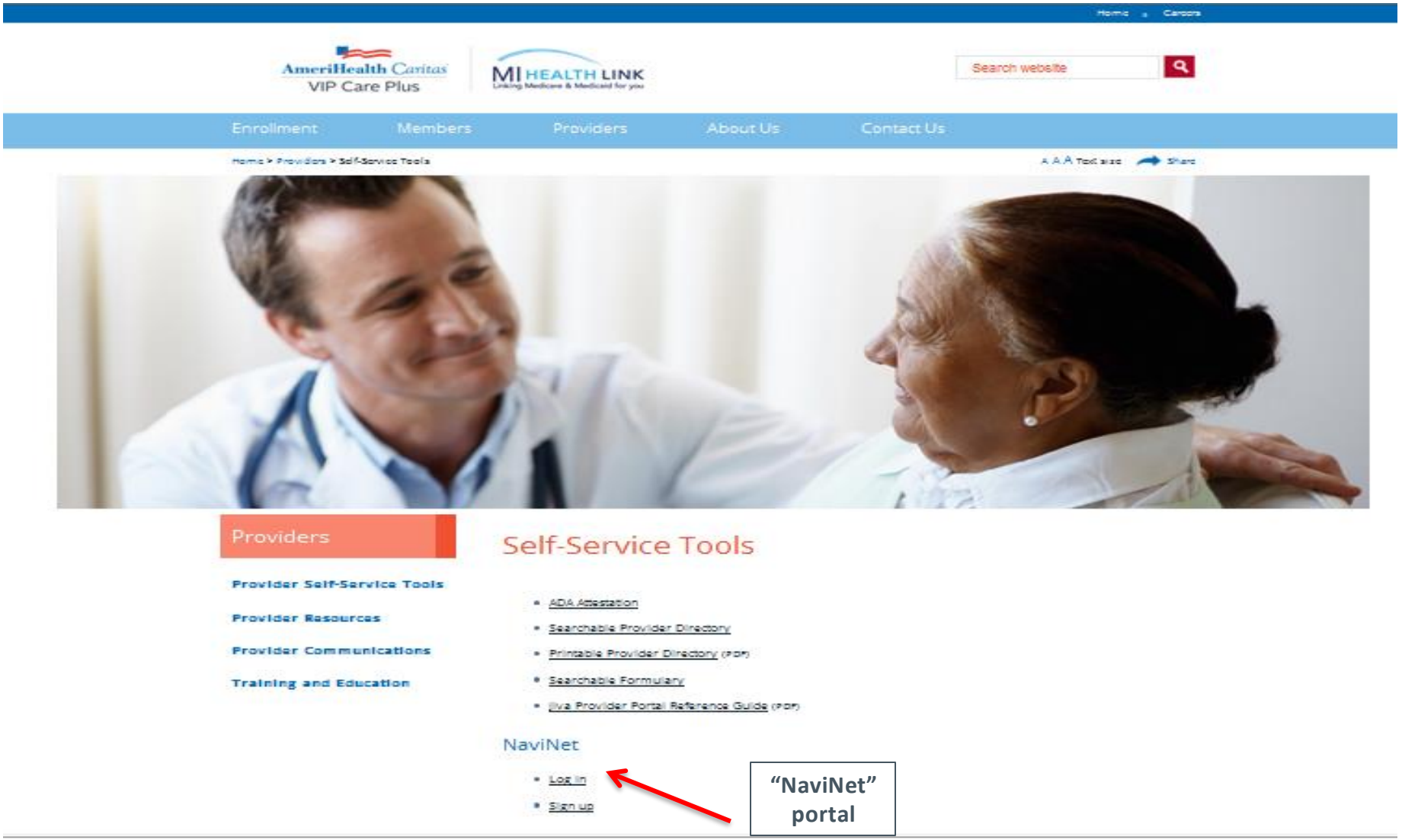
- 1-800-975-7630 to speak with an enrollment counselor Monday through Friday from 8 a.m. - 7 p.m.
- TTY users should call 1-888-263-5897.

If individuals who want to enroll have questions they can:

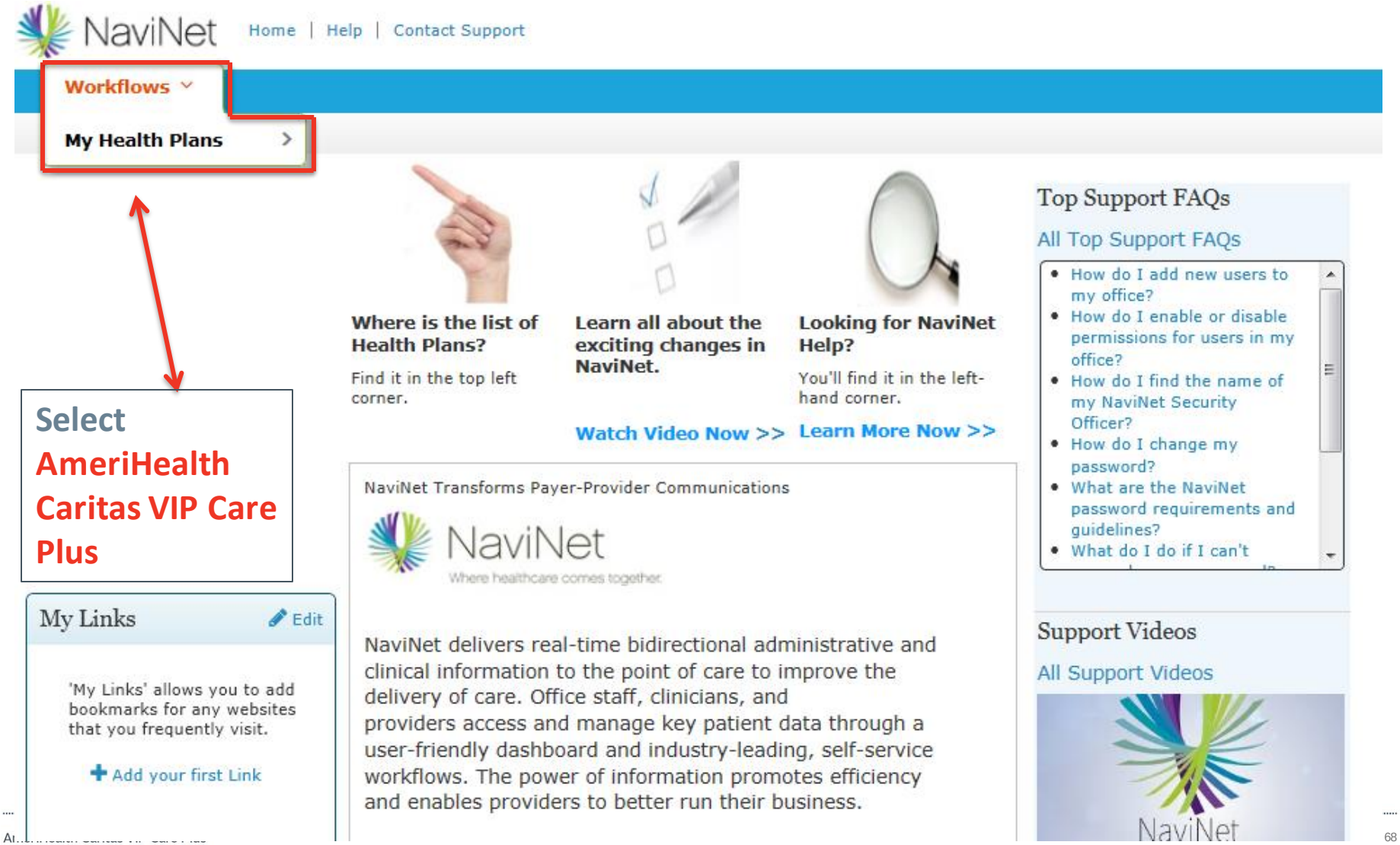
- Call the plan they are interested in directly.
- Call Michigan ENROLLS at 1-800-975-7630 to speak with an enrollment counselor Monday through Friday from 8 a.m. - 7 p.m.

**MI Health Link Plans have no ability to enroll or dis-enroll individuals.**

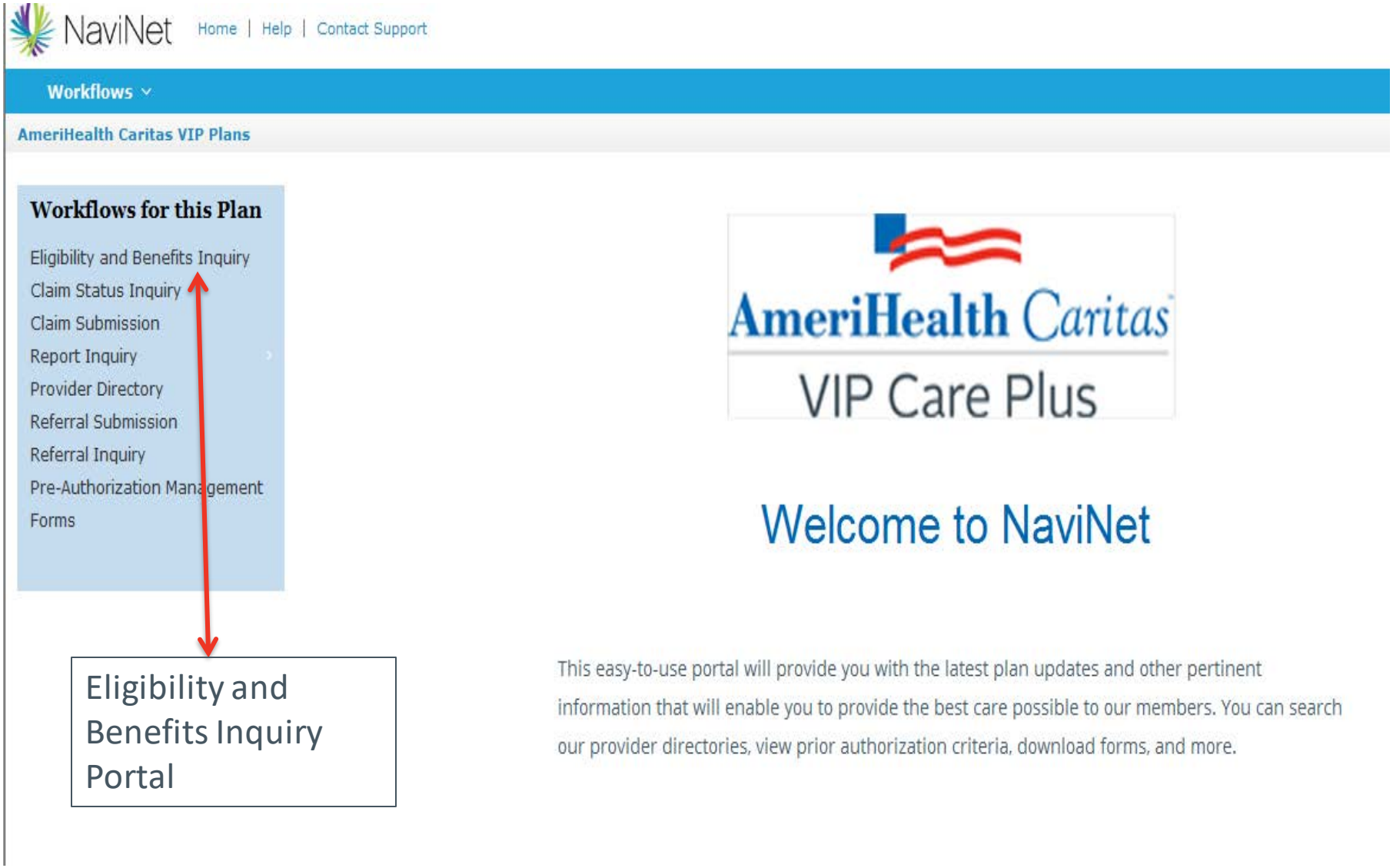
# Member Eligibility – Using NaviNet to Verify Eligibility (log on directly or from the AmeriHealth Caritas VIP Care Plus Provider Page)



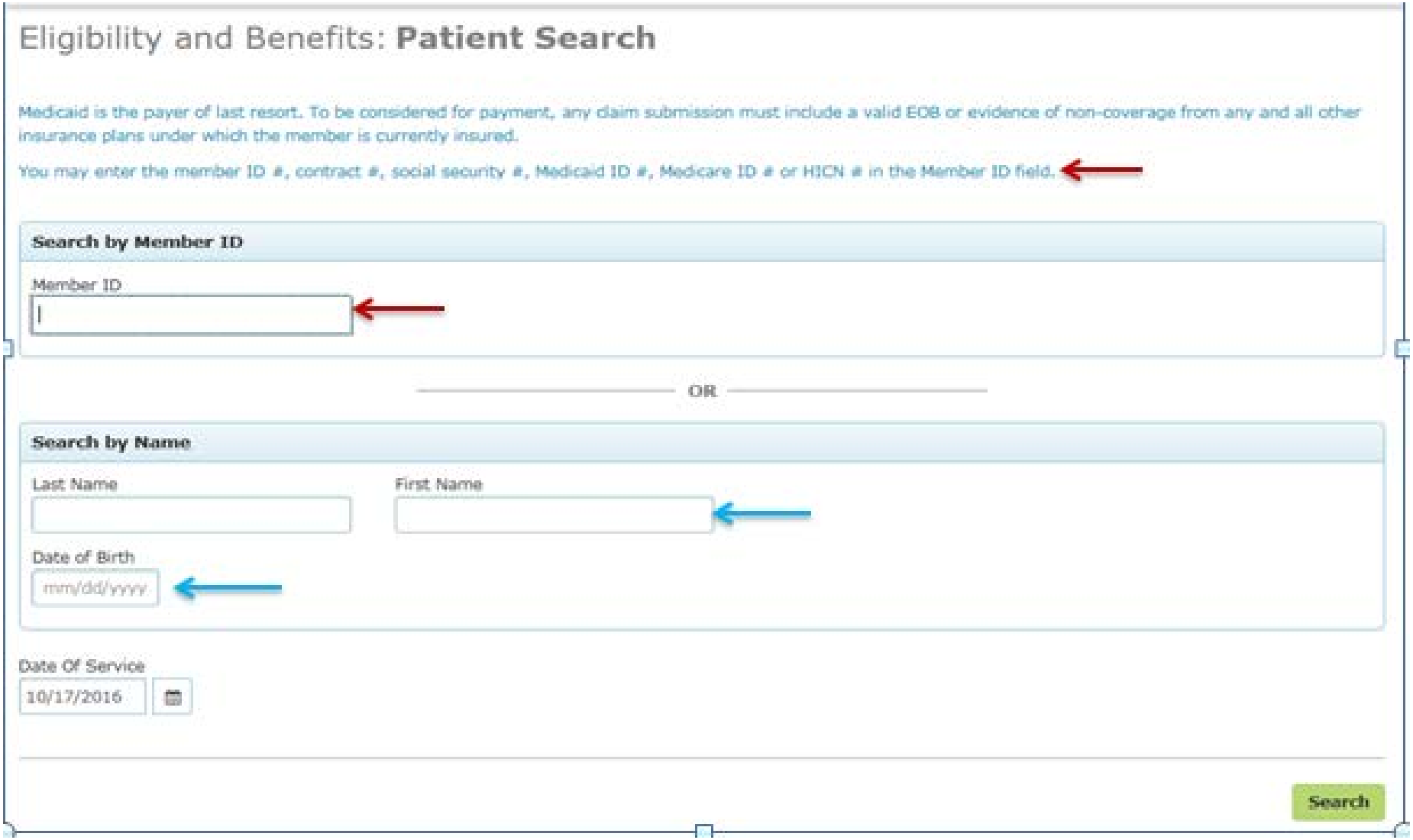
# Member Eligibility – Using NaviNet to Verify Eligibility (NaviNet Home Page)



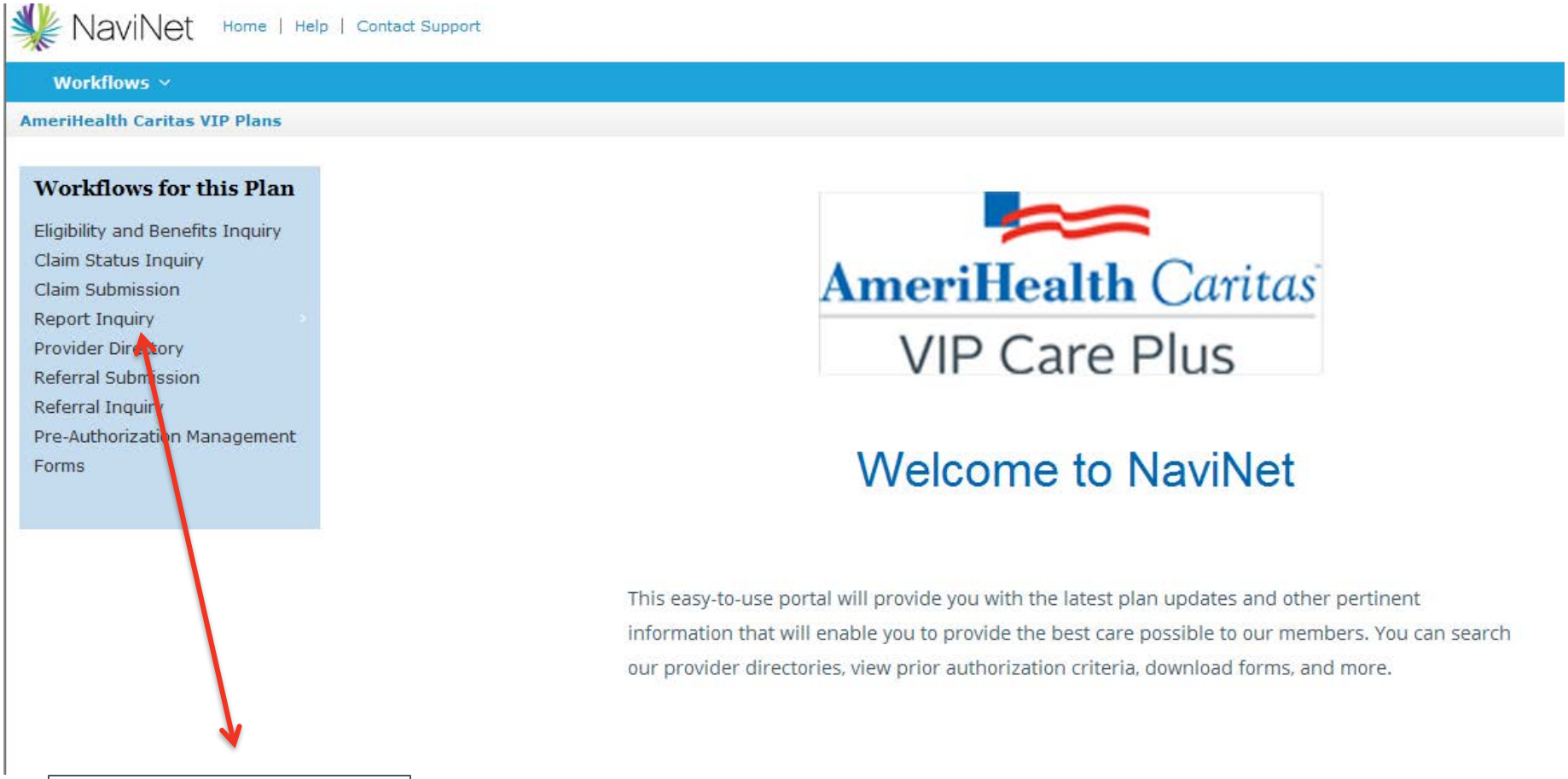
# Member Eligibility – Using NaviNet to Verify Eligibility (NaviNet Health Plan Page)



# Member Eligibility – Using NaviNet to Verify Eligibility (NaviNet Health Plan Member Eligibility and Benefits Inquiry Page)

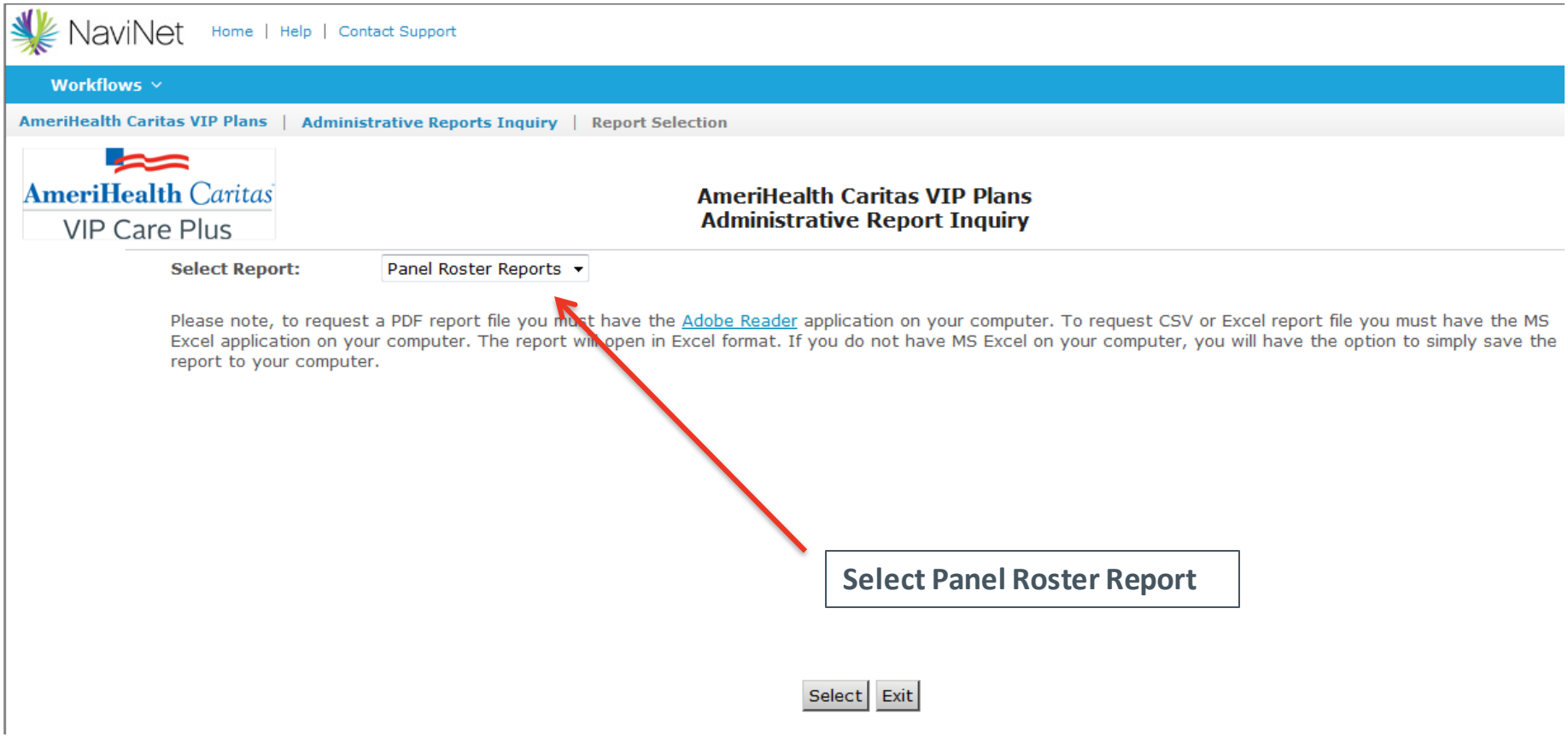


# Member Eligibility – Using NaviNet to Verify Eligibility (NaviNet Health Plan Page)

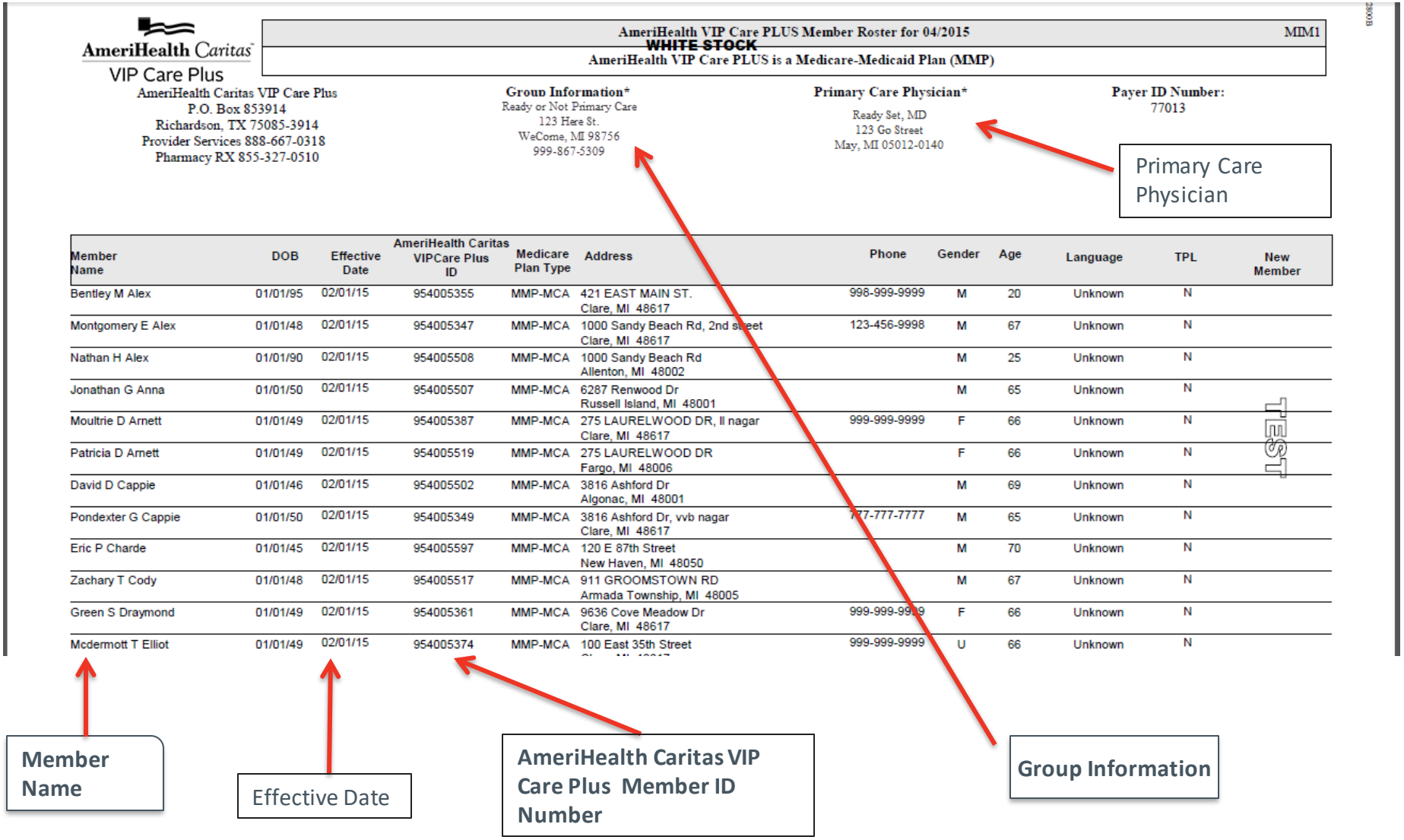



**Select Report Inquiry**

# Panel Roster Reports



# Panel Roster



AmeriHealth Caritas VIP Care Plus

**AmeriHealth VIP Care PLUS Member Roster for 04/2015** MIM1

WHITE STOCK

**AmeriHealth VIP Care PLUS is a Medicare-Medicaid Plan (MMP)**

AmeriHealth Caritas VIP Care Plus
P.O. Box 853914
Richardson, TX 75085-3914
Provider Services 888-667-0318
Pharmacy RX 855-327-0510

**Group Information***
Ready or Not Primary Care
123 Here St.
WeCome, MI 98756
999-867-5309

**Primary Care Physician***
Ready Set, MD
123 Go Street
May, MI 05012-0140

**Payer ID Number:**
77013

Primary Care Physician

| Member Name | DOB | Effective Date | AmeriHealth Caritas VIPCare Plus ID | Medicare Plan Type | Address | Phone | Gender | Age | Language | TPL | New Member |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Bentley M Alex | 01/01/95 | 02/01/15 | 954005355 | MMP-MCA | 421 EAST MAIN ST. Clare, MI 48617 | 998-999-9999 | M | 20 | Unknown | N | |
| Montgomery E Alex | 01/01/48 | 02/01/15 | 954005347 | MMP-MCA | 1000 Sandy Beach Rd, 2nd street Clare, MI 48617 | 123-456-9998 | M | 67 | Unknown | N | |
| Nathan H Alex | 01/01/90 | 02/01/15 | 954005508 | MMP-MCA | 1000 Sandy Beach Rd Allenton, MI 48002 | | M | 25 | Unknown | N | |
| Jonathan G Anna | 01/01/50 | 02/01/15 | 954005507 | MMP-MCA | 6287 Renwood Dr Russell Island, MI 48001 | | M | 65 | Unknown | N | |
| Moultrie D Arnett | 01/01/49 | 02/01/15 | 954005387 | MMP-MCA | 275 LAURELWOOD DR, ll nagar Clare, MI 48617 | 999-999-9999 | F | 66 | Unknown | N | |
| Patricia D Arnett | 01/01/49 | 02/01/15 | 954005519 | MMP-MCA | 275 LAURELWOOD DR Fargo, MI 48006 | | F | 66 | Unknown | N | |
| David D Cappie | 01/01/46 | 02/01/15 | 954005502 | MMP-MCA | 3816 Ashford Dr Algonac, MI 48001 | | M | 69 | Unknown | N | |
| Pondexter G Cappie | 01/01/50 | 02/01/15 | 954005349 | MMP-MCA | 3816 Ashford Dr, vvb nagar Clare, MI 48617 | 777-777-7777 | M | 65 | Unknown | N | |
| Eric P Charde | 01/01/45 | 02/01/15 | 954005597 | MMP-MCA | 120 E 87th Street New Haven, MI 48050 | | M | 70 | Unknown | N | |
| Zachary T Cody | 01/01/48 | 02/01/15 | 954005517 | MMP-MCA | 911 GROOMSTOWN RD Armada Township, MI 48005 | | M | 67 | Unknown | N | |
| Green S Draymond | 01/01/49 | 02/01/15 | 954005361 | MMP-MCA | 9636 Cove Meadow Dr Clare, MI 48617 | 999-999-9999 | F | 66 | Unknown | N | |
| Mcdermott T Elliot | 01/01/49 | 02/01/15 | 954005374 | MMP-MCA | 100 East 35th Street | 999-999-9999 | U | 66 | Unknown | N | |

TEST

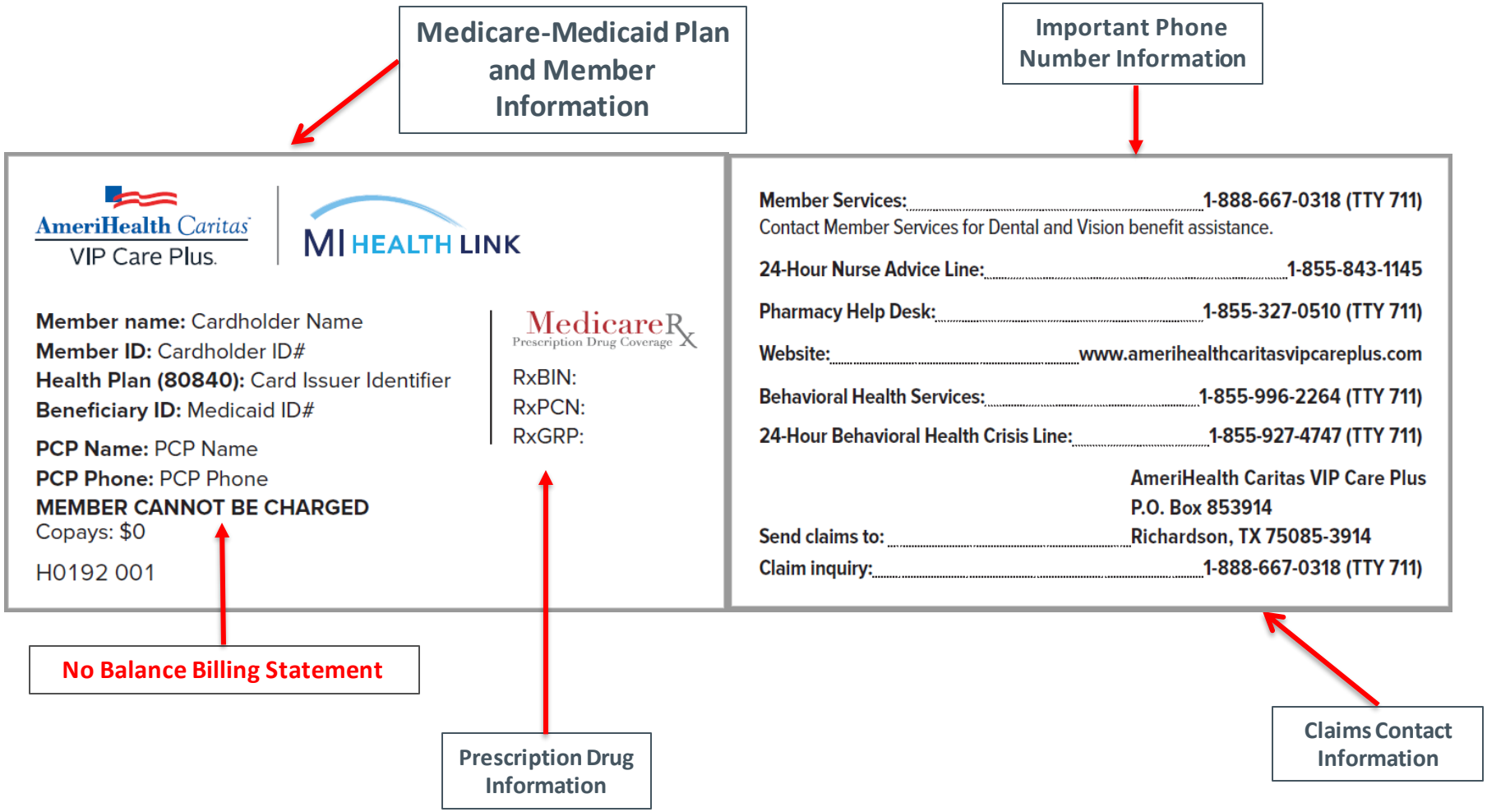
**Member Name**

Effective Date

**AmeriHealth Caritas VIP Care Plus Member ID Number**

**Group Information**

# Member Eligibility – Member ID Card



# Access to Care Standards

# Access to Care Standards

AmeriHealth VIP Care Plus endorses and promotes comprehensive and consistent access standards for members to assure member accessibility to health care services.

AmeriHealth VIP Care Plus has established mechanisms for measuring compliance with existing standards and identifies opportunities for the implementation of interventions for improving accessibility to health care services for members.

# Appointment Scheduling Standards

| Provider Type | Appointment Type | Availability Standard |
|---|---|---|
| Primary Care Physician (PCP) | Emergency Care | Twenty-four (24) hours per day, seven (7) days per week |
| | After-hours Care | Twenty-four (24) hours per day, seven (7) days per week |
| | Urgent, Acute Care | Within twenty-four (24) hours |
| | Routine Primary Care (Non-Urgent, Symptomatic) | Within ten (10) calendar days |
| | Preventive Care (Non-Symptomatic) | Within (30) calendar days |
| | Medical Follow-Up to Inpatient Care | Within seven (7) calendar days of discharge |
| High-Volume Specialists (Cardiologists, Oncologists, Ophthalmologists, Orthopedic Surgeons, General Surgeons, Gastroenterologists, Pulmonologists, Otolaryngologists and Specialists in Physical Medicine and Rehabilitation) | Routine | Within thirty (30) calendar days |

# Prior Authorizations/Organizational Determinations

AmeriHealth Caritas
VIP Care Plus

# Prior Authorizations — Benefits of Using Prior Authorizations

## Prior authorization:

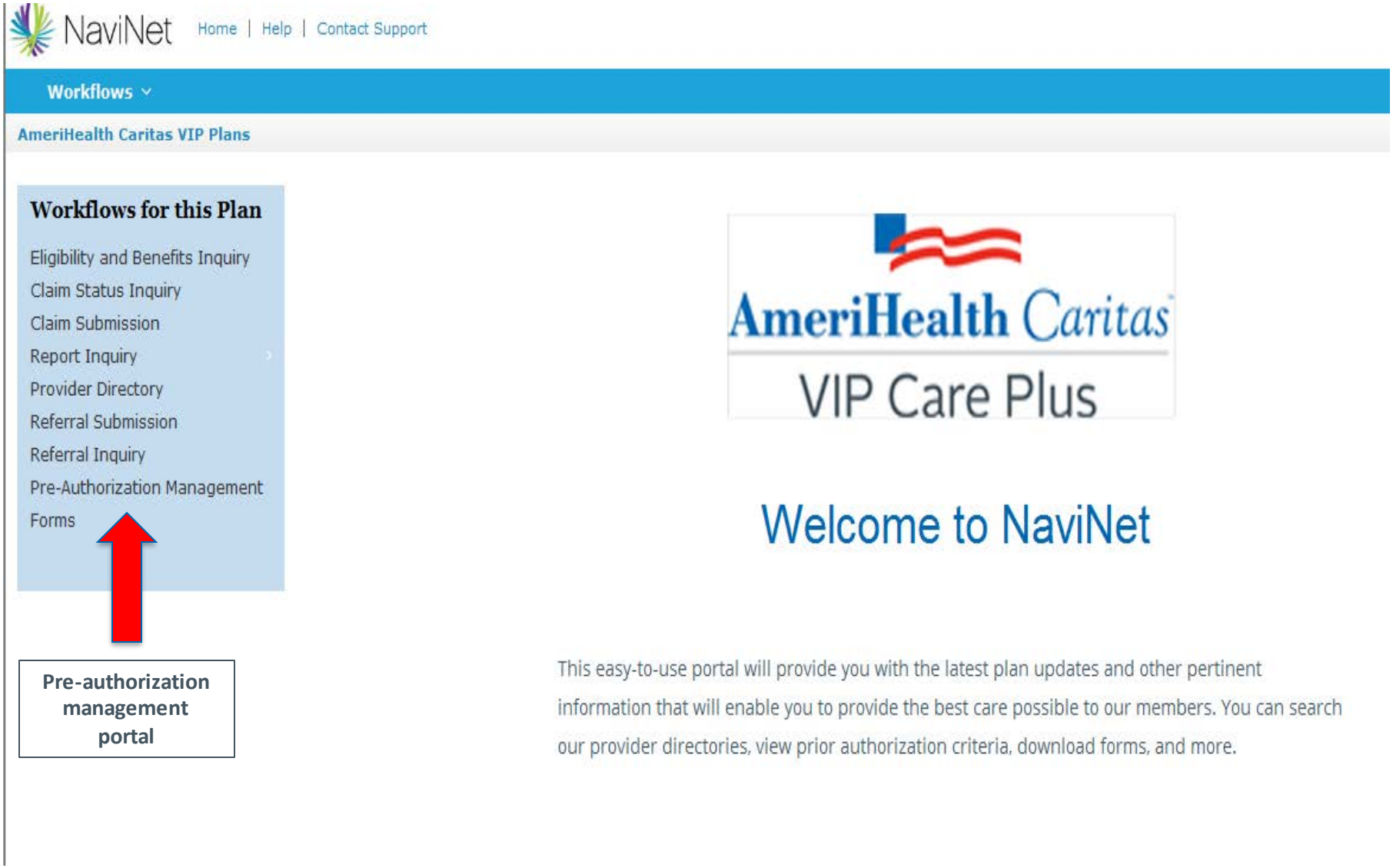
- Ensures the patient receives the right care for the right condition.
- Helps identify members who may not be engaged in the Care Management process.
- Provides a better picture for the Interdisciplinary Care Team, enabling them to develop comprehensive care plans.

# Prior Authorizations — Where to Submit Organization Determination Requests

**To submit a request for an organization determination, use:**

- NaviNet
- Prior Authorization Line: 1-866-263-9011
- Fax: 1-866-263-9036

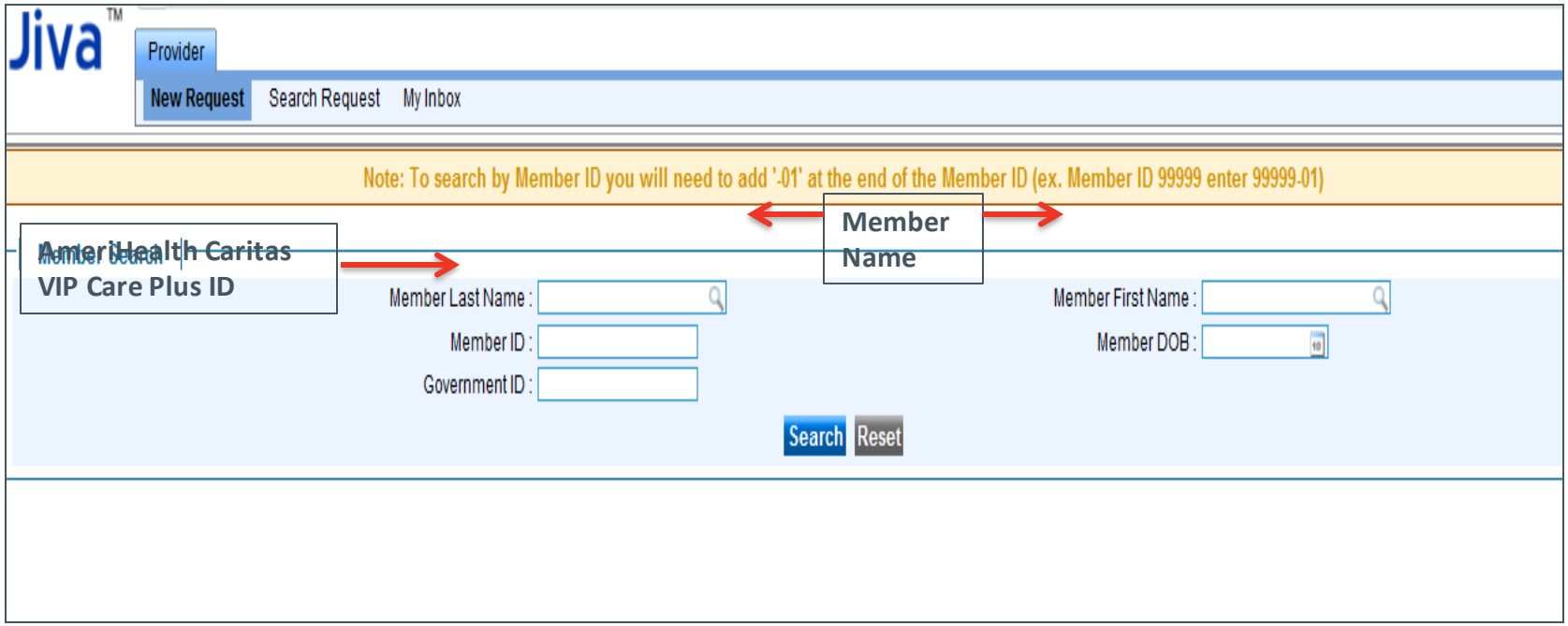
# Prior Authorizations — NaviNet Portal to Prior Authorization Management



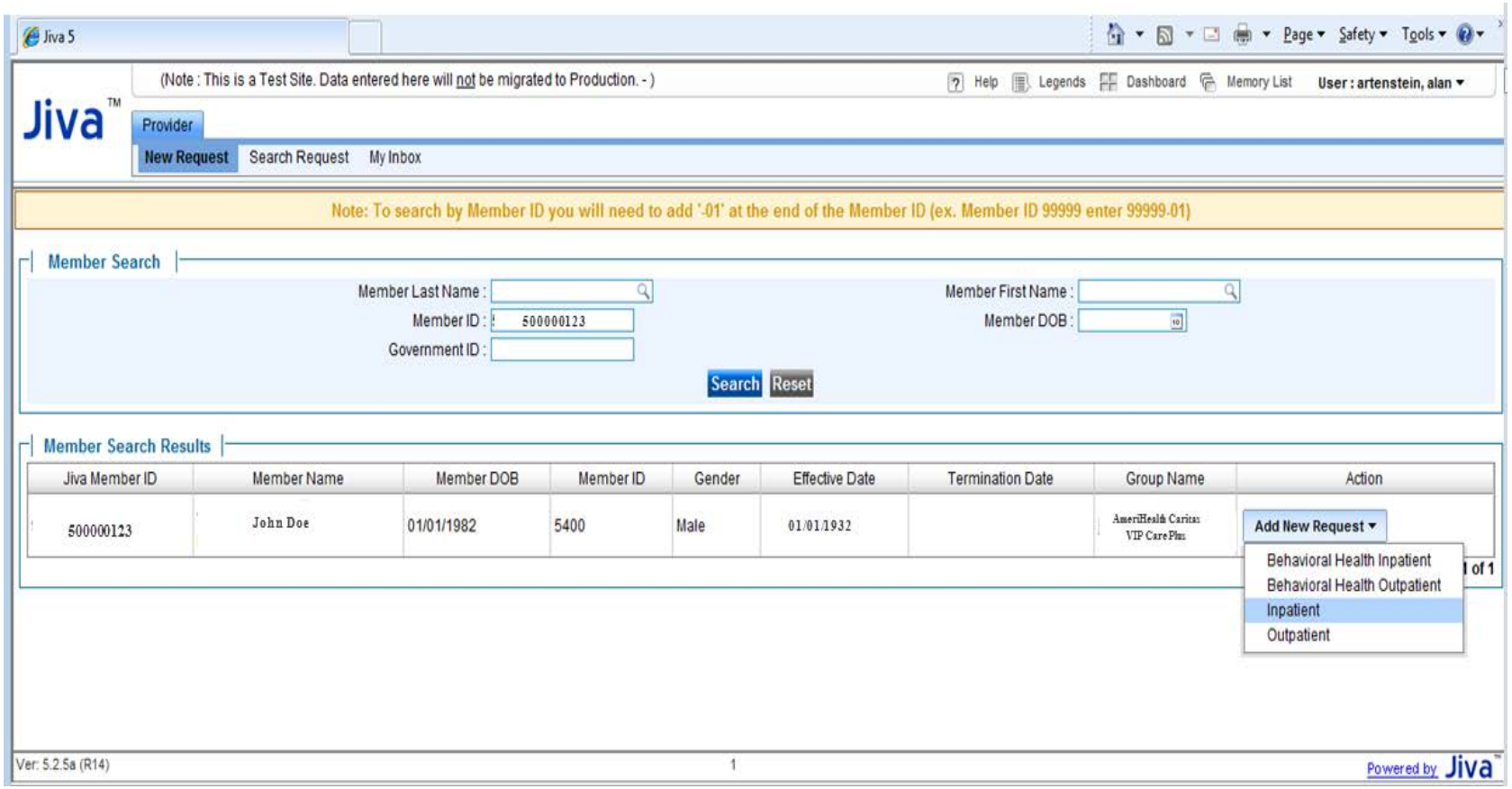

**Pre-authorization management portal**

# Prior Authorizations — Jiva Member Search Page

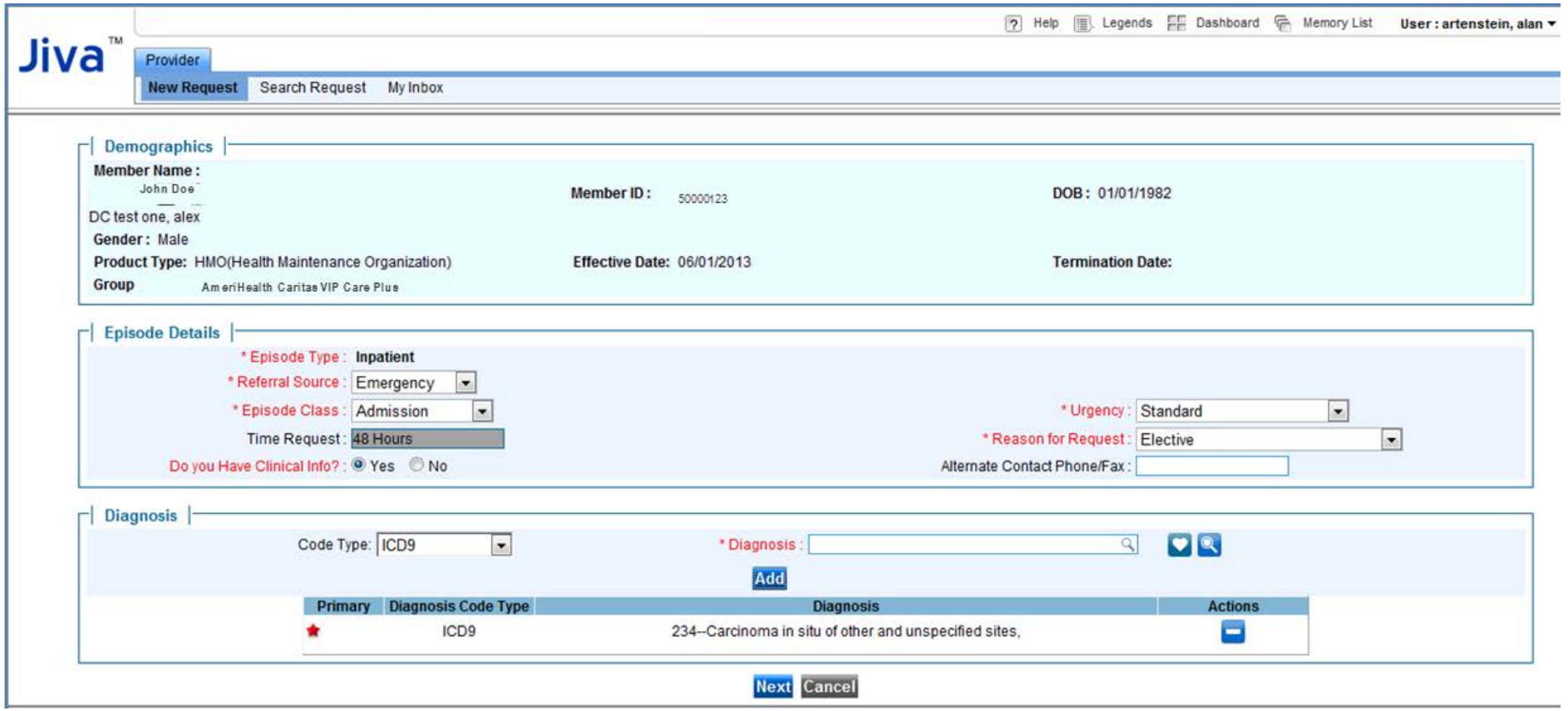
You will be linked to the AmeriHealth Caritas VIP Care Plus authorization system called Jiva to enter the authorization request:



# Prior Authorizations — Jiva Request Type

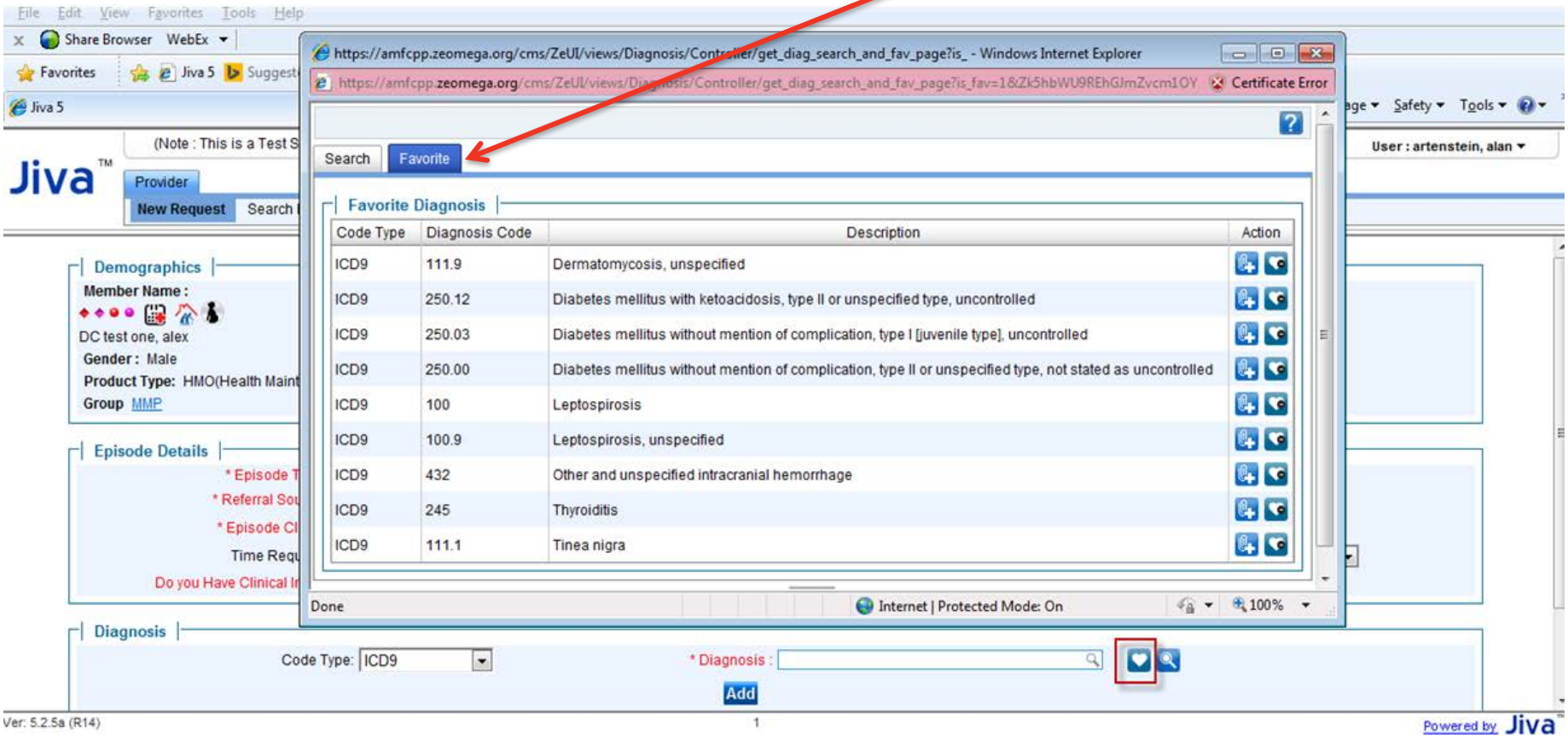


# Prior Authorizations — Jiva Episode Details

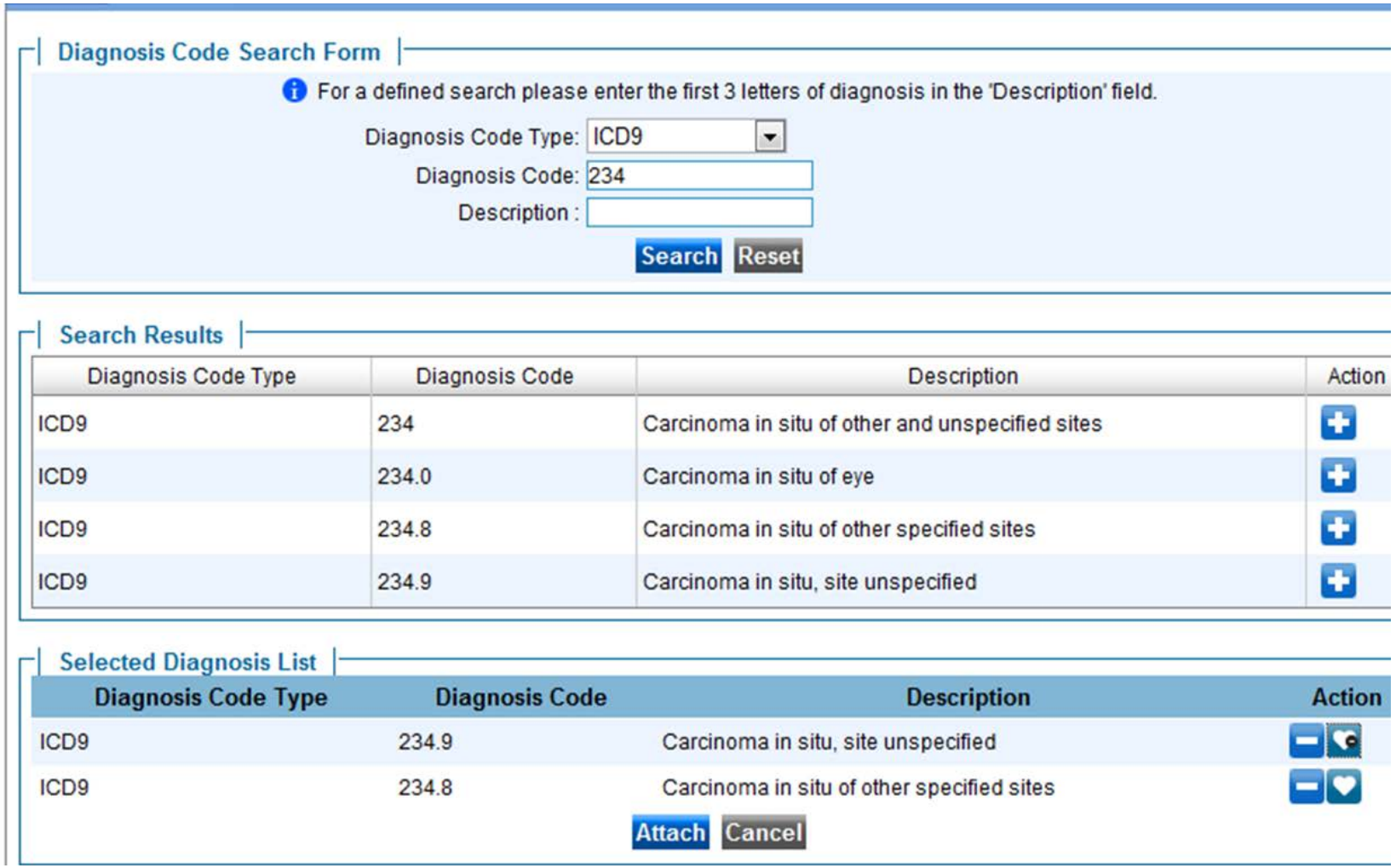



**All information in Red is required for a valid Prior Authorization request.**

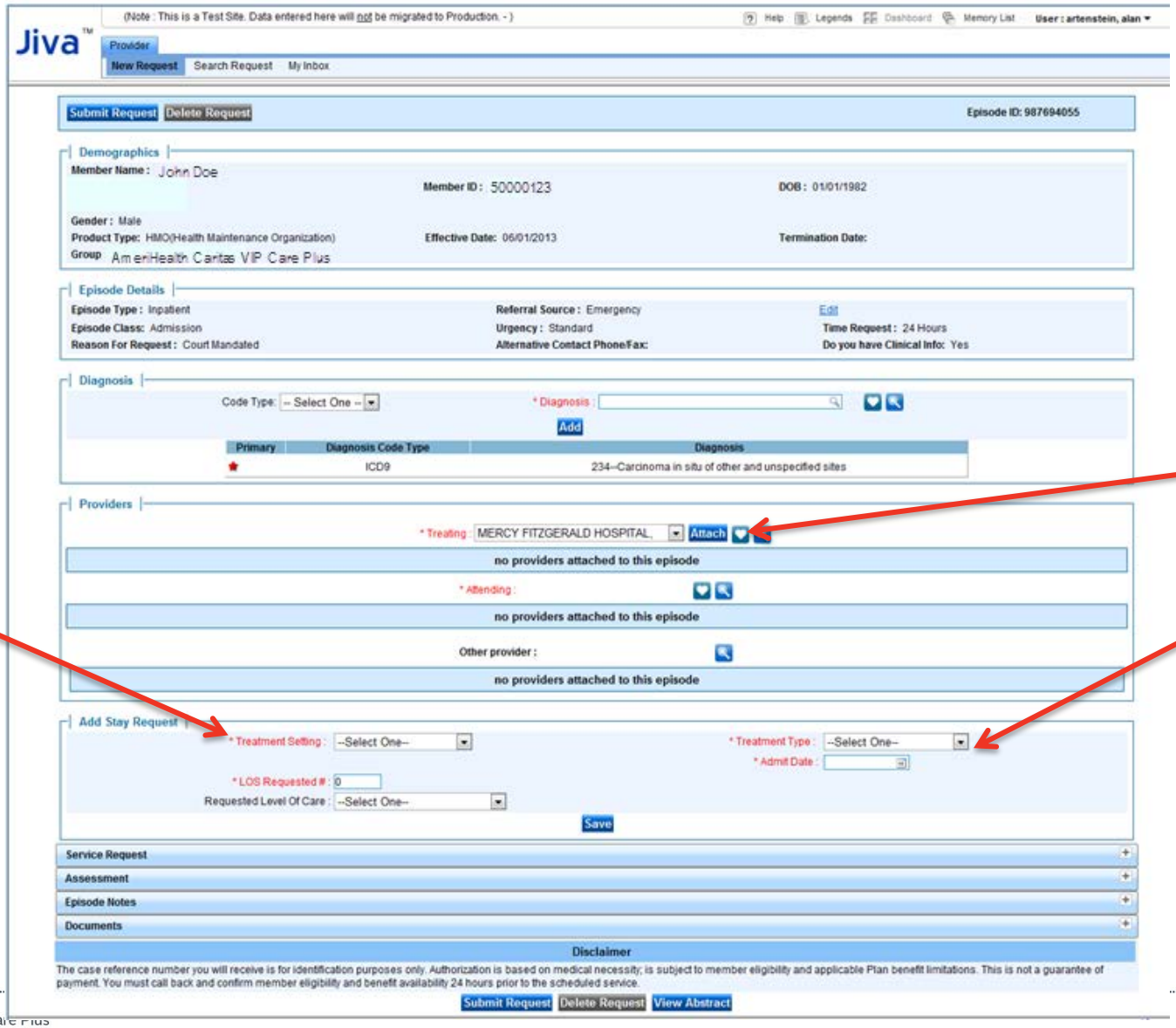
# Prior Authorizations — Jiva Favorite Diagnosis



# Prior Authorizations — Jiva Searchable Diagnosis



# Prior Authorizations — Jiva Provider Information and Procedure/Treatment

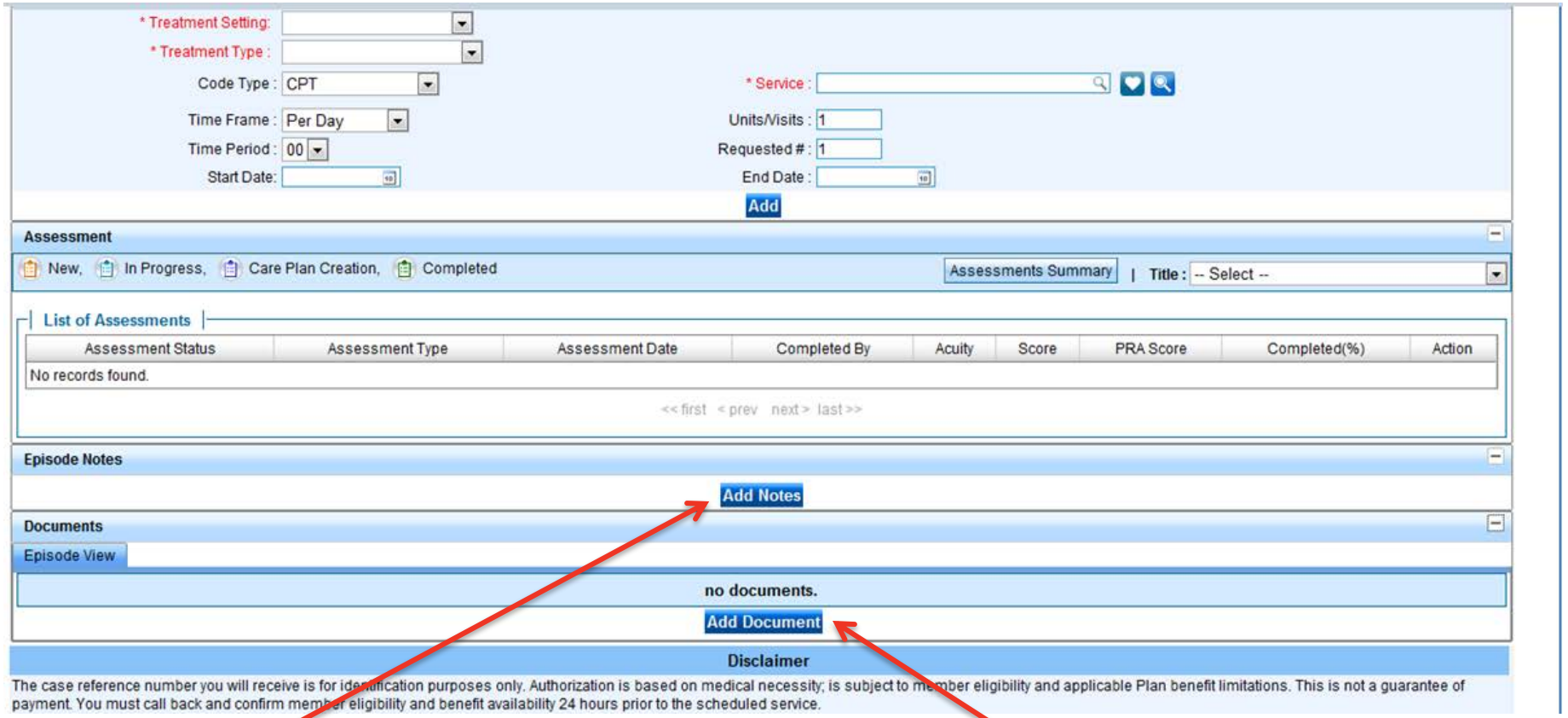



Treating Provider

Treatment Setting

Treatment Type

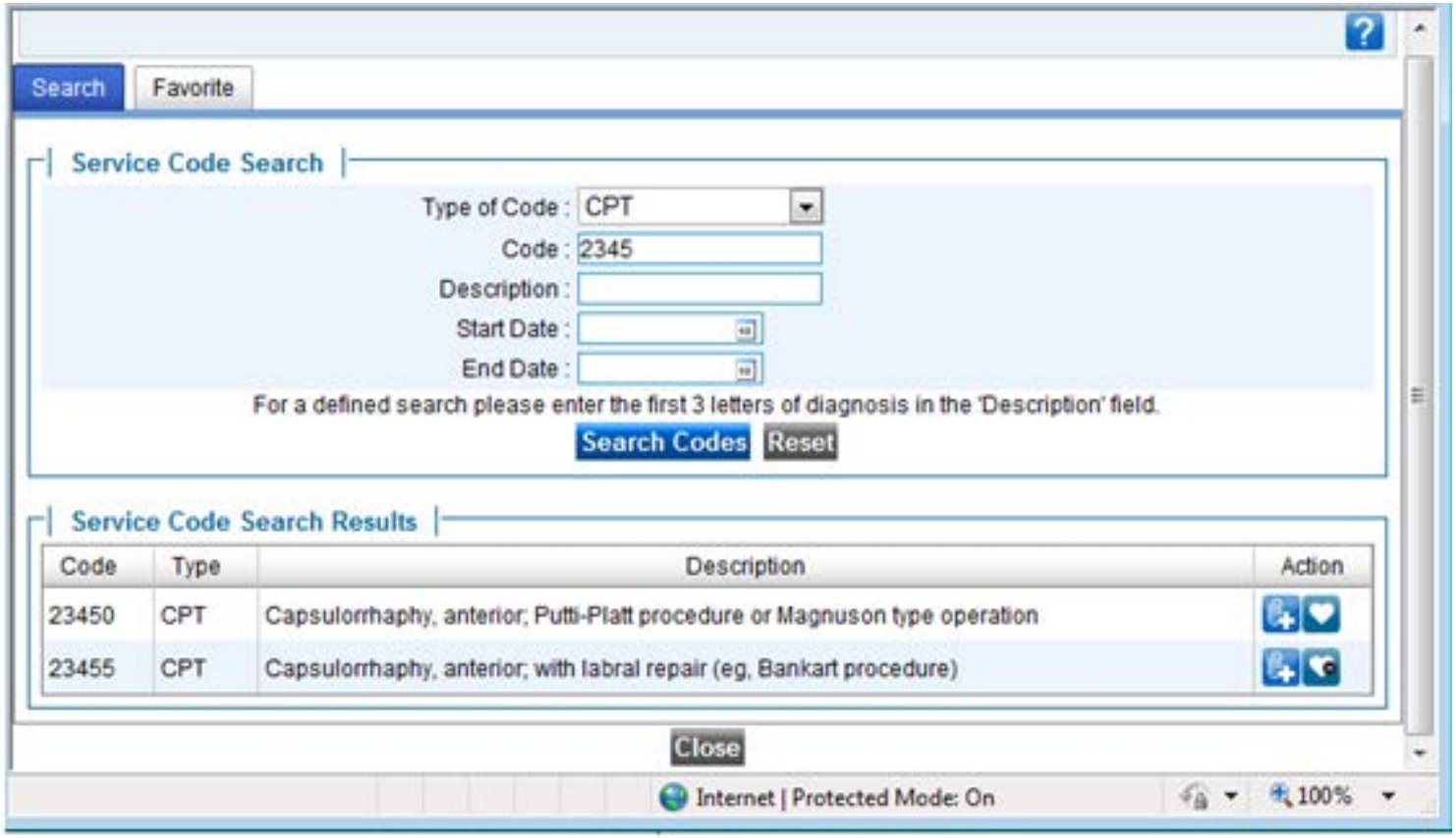
# Prior Authorizations — Jiva Assessments and Clinical Information



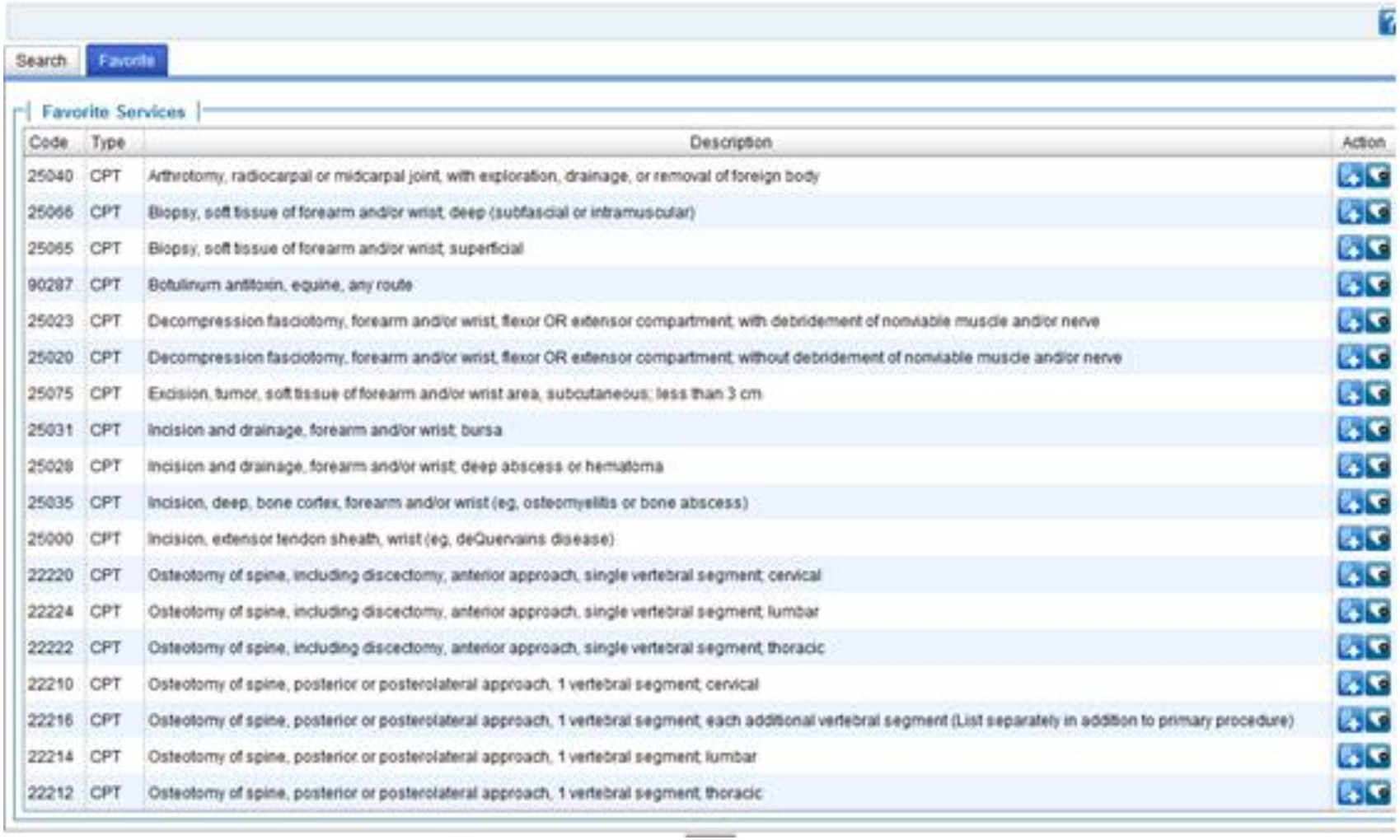

Add Assessments

**Must Upload ClinicalDocumentation For Request To Be Valid**

# Prior Authorizations — Jiva Procedure Search



# Prior Authorizations — Jiva Procedure Codes “Favorites”



Search | Favorite

Favorite Services

| Code | Type | Description | Action |
|---|---|---|---|
| 25040 | CPT | Arthrotomy, radiocarpal or midcarpal joint, with exploration, drainage, or removal of foreign body | |
| 25066 | CPT | Biopsy, soft tissue of forearm and/or wrist; deep (subfascial or intramuscular) | |
| 25065 | CPT | Biopsy, soft tissue of forearm and/or wrist; superficial | |
| 90287 | CPT | Botulinum antitoxin, equine, any route | |
| 25023 | CPT | Decompression fasciotomy, forearm and/or wrist, flexor OR extensor compartment; with debridement of nonviable muscle and/or nerve | |
| 25020 | CPT | Decompression fasciotomy, forearm and/or wrist, flexor OR extensor compartment; without debridement of nonviable muscle and/or nerve | |
| 25075 | CPT | Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; less than 3 cm | |
| 25031 | CPT | Incision and drainage, forearm and/or wrist; bursa | |
| 25028 | CPT | Incision and drainage, forearm and/or wrist; deep abscess or hematoma | |
| 25035 | CPT | Incision, deep, bone cortex, forearm and/or wrist (eg, osteomyelitis or bone abscess) | |
| 25000 | CPT | Incision, extensor tendon sheath, wrist (eg, deQuervains disease) | |
| 22220 | CPT | Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; cervical | |
| 22224 | CPT | Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; lumbar | |
| 22222 | CPT | Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; thoracic | |
| 22210 | CPT | Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; cervical | |
| 22216 | CPT | Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; each additional vertebral segment (List separately in addition to primary procedure) | |
| 22214 | CPT | Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar | |
| 22212 | CPT | Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; thoracic | |

# Prior Authorizations - Time Frames

- AmeriHealth Caritas VIP Care Plus has up to fourteen (14) calendar days to complete a standard request for prior authorization and notify the provider of the organization determination.
- AmeriHealth Caritas VIP Care Plus has seventy-two (72) hours to complete an expedited request.
- Once an authorization is processed, the AmeriHealth Caritas VIP Care Plus provider will receive a phone call and a fax alerting him or her to the organization determination.
- Providers may only request a peer-to-peer review during initial outreach by the Clinical Care Reviewer notifying the provider that the request is not meeting for medical necessity and will be pended to the Medical Director for determination. The peer-to-peer must occur before the decision is rendered.

# Prior Authorizations - Organization Determination Process

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

# Notice of Denial

**Important:** This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information."

## Notice of Denial of Medical [Coverage/Payment]

---

**Date:**

**Member number:**

**Name:**

**Service Subject to Notice:**

**Type of Service:** [*Medicare-only, Medicaid-only, both Medicare and Medicaid*]

**Date of Service:**

**Provider Name:**

---

### Your request was denied

We've [denied, stopped, reduced, suspended] the [*payment of*] medical services/items listed below requested by you or your provider:

### Why did we deny your request?

We [denied, stopped, reduced, suspended] the [*payment of*] medical services/items listed above because [*Provide specific rationale for decision and include State or Federal law and/or Evidence of Coverage provisions to support decision*]:

---

---

---

---

### You have the right to appeal our decision

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

- Elective/non-emergent air ambulance transportation
- All out-of-network services (except emergency services)
- Inpatient services
- Certain outpatient diagnostic tests
- Home health services
- Therapy and related services
- Transplants (including transplant evaluations)
- Certain durable medical equipment (DME)
- Surgery and some surgical services
- Religious nonmedical health care institutions
- Hyperbaric oxygen
- Gastric bypass or vertical band gastroplasty
- Hysterectomy
- Pain management
- Radiology outpatient services:
  - CT scan
  - PET scan
  - MRI

- **For services not typically covered under Medicare, providers must still request an organization determination.**
- ***Exceptions apply. For a full list of services that require prior authorizations, please refer to the Provider Manual or call Care Management.**

# Services that do NOT require Prior Authorization

- Emergency services
- Women's health specialist services (to provide women's routine and preventive health care services)
- Low-level plain films – i.e. x-rays, etc.
- EKGs
- Post stabilization services (in-network and out-of-network)
- Imaging procedures related to emergency room services, observation care and inpatient care
- Laboratory services
- Ultrasounds
- Non-emergent medically necessary ambulance transportation to or from a Medicare/Medicaid covered facility

# Member Appeals

Members, their authorized representative, including providers, may file appeals with AmeriHealth Caritas VIP Care Plus:

- Initial appeals must be filed with AmeriHealth Caritas VIP Care Plus.
- Next level appeals for Medicare A and B only benefits will be reviewed by the Medicare Independent Review Entity (IRE) and are filed automatically.
- Next level appeals for Medicaid only benefits will be reviewed through the Michigan Administrative Hearings System (MAHS) and/or a request for an External Review with the Michigan Department of Insurance and Financial Services (DIFS) and must be initiated by the member.
- Next level appeals for benefits that overlap will automatically go to the IRE and the member may also submit to MAHS and/or External Review with DIFS.

# Member Appeal Time Frames

**Appeals must be initiated within:**

- 12 days of the date of the denial notice or before the service is stopped/reduced, whichever is later, in order for services to continue while the case is being reviewed.
- 60 calendar days from the date of the denial notice.
- 120/127 calendar days from the date of the 1st level appeal denial notice for MAHS/DIFS appeal requests.

**Appeals must be resolved within:**

- 30 calendar days for standard appeals with AmeriHealth Caritas VIP Care Plus.
- Independent Review Entity (IRE) appeals follow existing Medicare appeal time frames.
- 90/14-21 calendar days for MAHS/DIFS.
- 72 hours for all expedited appeals.

# Member Grievances

Members also have the right to file grievances with AmeriHealth Caritas VIP Care Plus regarding any area of dissatisfaction they have with the Plan or provider, such as:

- Provider office staff rudeness
- Customer Service hold time was too long
- Their prescription brand is not covered under the formulary
- Quality of care concerns

AmeriHealth Caritas VIP Care Plus has 30 calendar days to research and respond to these grievances which can either be found unsubstantiated or substantiated. If found to be substantiated, education of the provider's office or internal staff may occur.

# Claims

AmeriHealth Caritas
VIP Care Plus

# Claims – The Benefits of Using Electronic Claims and EFT

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

# Claims – How to Sign Up for Electronic Claim Processing through Change Healthcare

AmeriHealth Caritas VIP Care Plus partners with Change Healthcare to provide electronic claims submission, electronic funds transfer, and electronic remittance advices.

**The first step is to contact your practice management system vendor or clearinghouse to verify if you are currently signed up with Change Healthcare or need to initiate the process.**

- **Change Healthcare's toll free number is: 1-877-363-3666.**
- **AmeriHealth Caritas VIP Care Plus Payer ID is: 77013.**

# Enrolling with Change Healthcare for EFT

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

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

**Note: In order to enroll for EFT, you will need your AmeriHealth Caritas VIP Care Plus provider number, which can be found on the paper remittance. This number will be required to fill in the Trading Partner ID field on the enrollment form.** If you cannot locate your provider number, please contact AmeriHealth Caritas VIP Care Plus Provider Services at 1-888-667-0318.

# Claims - How to Submit Paper Claims

Providers may submit new and corrected paper claims to:

AmeriHealth Caritas VIP Care Plus
Claims
P.O. Box 7074
London, KY 40742-7074

# How to File a Claim

- Please submit only one claim for both the Medicare and Medicaid covered services; file it as you would to Medicare.
- For Medicaid-only covered services, file the claim as you would file it to Medicaid.
- We will process the Medicare benefit and automatically crossover the claim to process under the Medicaid benefit.
- You will have 365 days from the date of service to submit claims.
- Your office will receive one remittance advice and one payment for both benefits.

# Claims – How to Re-submit a Claim

Upon receiving a remittance advice, if a provider determines that an error occurred upon submission of the claim, a provider may correct and resubmit the claim.

## For electronic claims:

- In loop 2300 in the CLM*05 03, enter the appropriate Claim Frequency Type code (billing code) 7 for a replacement/correction, or 8 to void a prior claim.
- In loop 2300 in the REF*F8*, include the last iteration of the claim number you are correcting.

## To resubmit a paper claim, the provider should:

- In box 22 of the HCFA 1500 include the appropriate resubmission code and in box 4 of the UB-04 the appropriate Bill Type.
- The last iteration of the claim number you are correcting in box 22 of the HCFA 1500 and box 64 of the UB-04.
- Mark the claim as corrected and submit to:

  AmeriHealth Caritas VIP Care Plus
  Claims
  P.O. Box 7074
  London, KY 40742-7074

# Claims Payment Example*

## Scenario # 1:

Provider Charges $150.00

Medicare Allowable $100.00

Medicare Payable Amount: $80.00 (80%)

Medicaid Allowable $75.00

Medicaid Payable Amount: $0.00 (Medicare paid more than Medicaid allowed so no additional payment)

Insurance Payable Amount: $80.00

## Scenario # 2:

Provider Charges $150.00

Medicare Allowable $100.00

Medicare Payable Amount: $80.00 (80%)

Medicaid Allowable $95.00

Medicaid Payable Amount: $15.00 (Medicaid allowed more than Medicare)

Insurance Payable Amount: $95.00

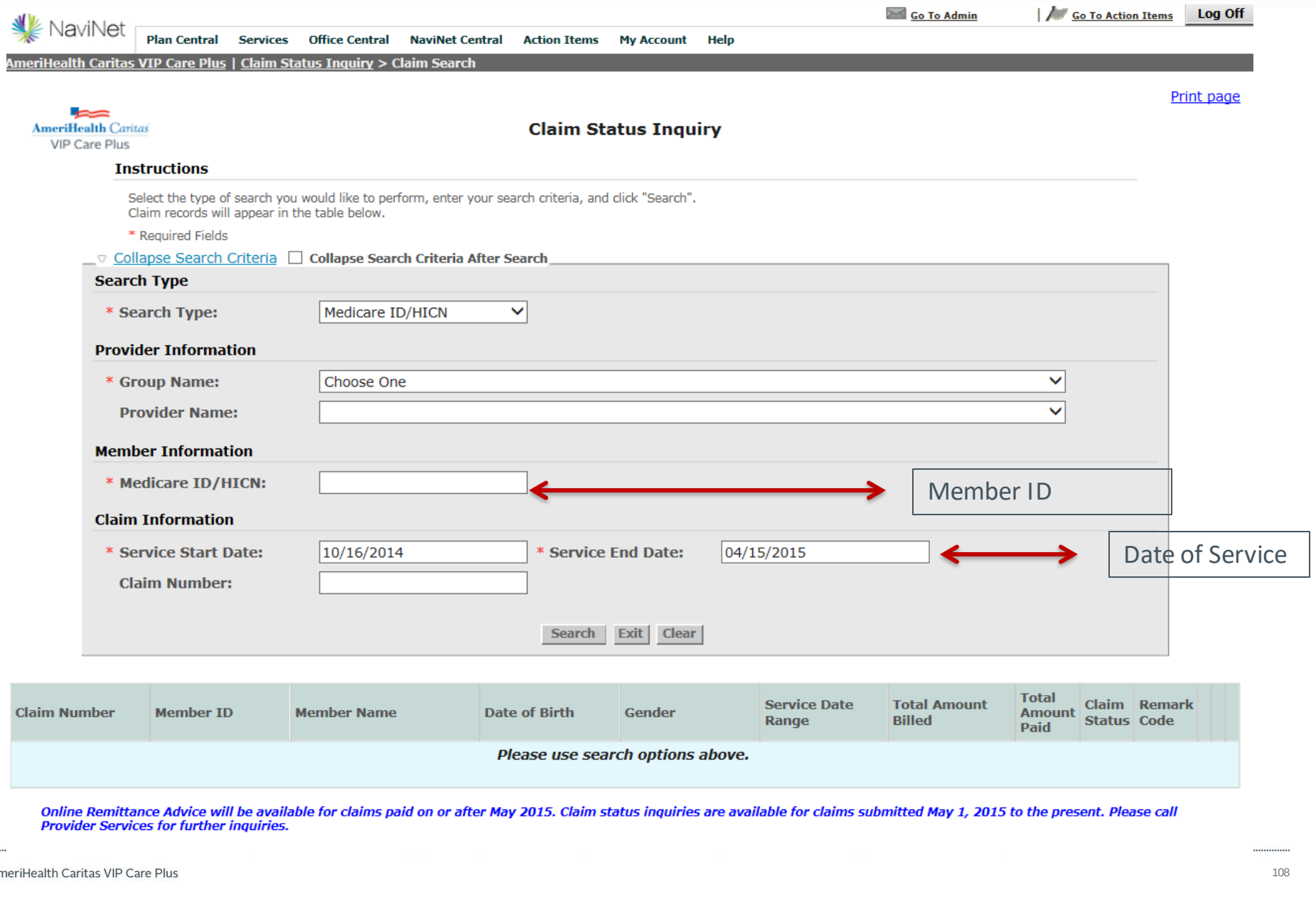
*Example only

# Claims – Provider Claim Inquiry / Dispute

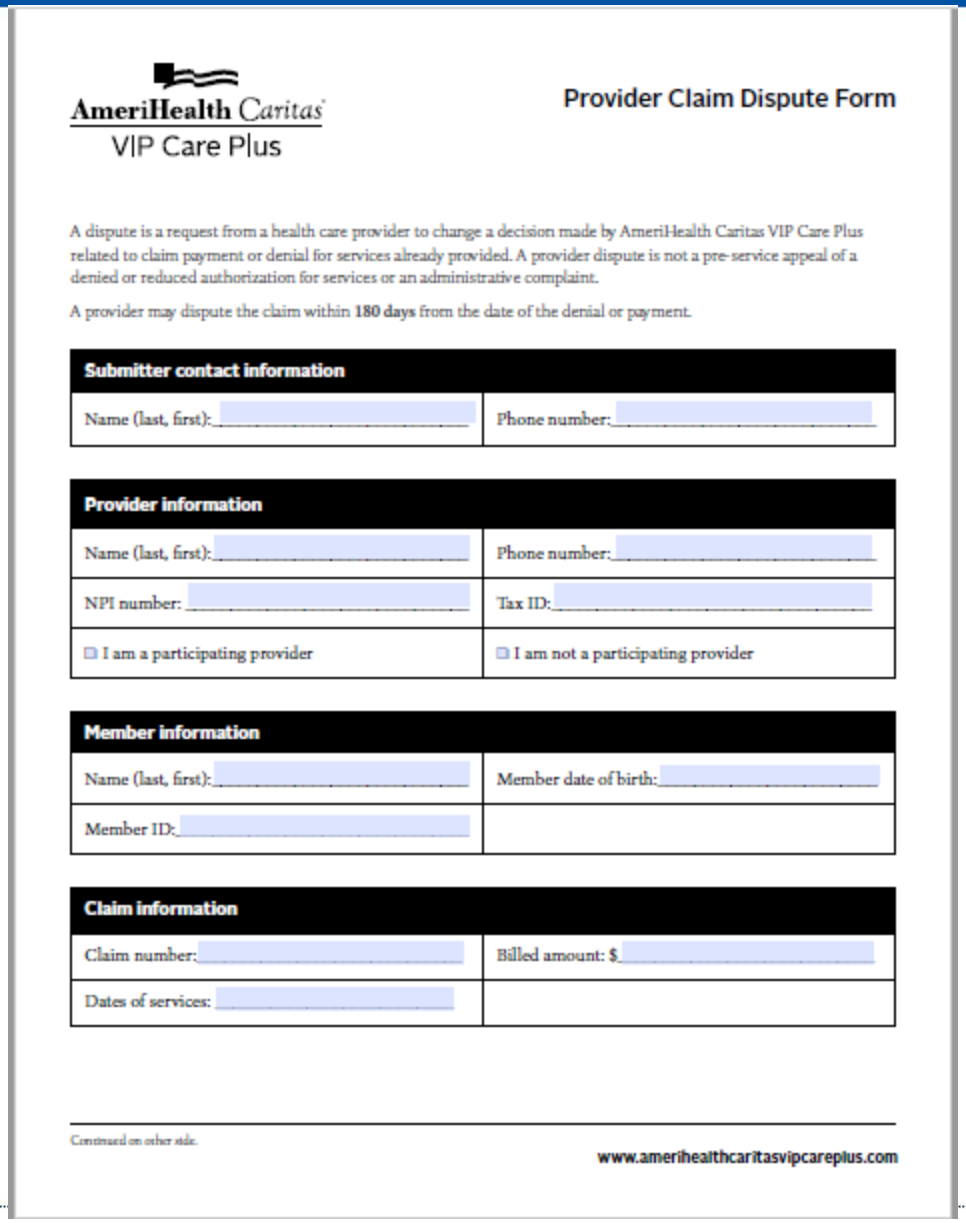
Real-time claim status is available via NaviNet or by calling Provider Services at 1-888-667-0318.

- AmeriHealth Caritas VIP Care Plus processes electronic claims on average in fourteen (14) calendar days and paper claims in thirty (30) calendar days.
- If a participating AmeriHealth Caritas VIP Care Plus provider has a question regarding the way a claim was processed or adjudicated, the provider may dispute the claim by calling Provider Services or in writing via Claim Dispute Form. This form is located on the AmeriHealth Caritas VIP Care Plus website under the Provider Resources tab. **This must be done within 180 days of the remittance advice date.**
    - Providers should submit all supporting documentation and an explanation as to why they believe the claim was processed or paid incorrectly.
    - We follow both Medicare and Medicaid guidelines, so please reference CMS and MDHHS manuals, memos, or other related documents for guidance.

# Using NaviNet for Claim Status



# Claims – Provider Claim Inquiry Form



AmeriHealth Caritas VIP Care Plus

## Provider Claim Dispute Form

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

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

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

| **Provider information** | |
|---|---|
| Name (last, first): | Phone number: |
| NPI number: | Tax ID: |
| ☐ I am a participating provider | ☐ I am not a participating provider |

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

| **Claim information** | |
|---|---|
| Claim number: | Billed amount: $ |
| Dates of services: | |

Continued on other side.

www.amerihealthcaritasvipcareplus.com

# Prohibition on Improperly Balance Billing

# Prohibition on 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 improperly billing qualified Medicare beneficiaries for Medicare cost-sharing.

# Prohibition on Balance Billing

For AmeriHealth Caritas VIP Care Plus members, providers **may not bill and/or collect** any Medicare cost-sharing amounts, including deductibles, coinsurance, and copayments that may be represented on the remit, as they are not the member's responsibility.

This practice, known as "improper billing", is prohibited by Federal Law and as stipulated under your AmeriHealth Caritas VIP Care Plus Provider Services Agreement.

# Prohibition on Balance Billing

**Please be advised that it is unlawful for providers to "improperly bill" any patient who is a member of AmeriHealth Caritas VIP Care Plus for any covered services.**

- No member may be improperly billed by any provider for services for any reason.
  - Members **cannot** be billed for the difference between the provider's usual and customary charge and the provider's contracted rate.
  - Members **cannot** be billed the difference between the amount billed by the provider and paid by AmeriHealth Caritas VIP Care Plus.
- This includes covered and non-covered services (unless a organizational determination has happened and a prior written agreement has been signed by both the provider and the AmeriHealth Caritas VIP Care Plus member for **non-covered** services).

# Prohibition on Balance Billing

- AmeriHealth Caritas VIP Care Plus members cannot be billed, nor can deposits be collected from AmeriHealth Caritas VIP Care Plus members, for any amounts other than the members' allowable cost-sharing.

- Members cannot be billed for missed appointments!

- If a member does not keep a scheduled appointment, you are not permitted to bill AmeriHealth Caritas VIP Care Plus for the missed appointment.

# What Can Members be Billed?

AmeriHealth Caritas VIP Care Plus Members **can** be billed for:

- Medicaid participation in cost of care amounts for long-term services and supports, as determined by MDHHS.

# How AmeriHealth VIP Care Plus Monitors Balance Billing

- If a provider inappropriately balance bills a member, the member may:
  - File a grievance with AmeriHealth Caritas VIP Care Plus
  - File a complaint with the Michigan Department of Community Health Ombudsman
- If the member files a grievance with AmeriHealth Caritas VIP Care Plus, the plan will investigate the grievance.
- If the member files a complaint with the Ombudsman, AmeriHealth Caritas VIP Care Plus will work in conjunction with the Ombudsman to provide any requested information.

## How the Plan Resolves Balance Billing Problems: Members

- If upon investigation of a grievance, AmeriHealth Caritas VIP Care Plus determines the member was inappropriately balance billed…
  - AmeriHealth Caritas VIP Care Plus informs the member of the outcome in writing, including an explanation that the member is not responsible for paying the balance billed amount.
  - If payment has been made to the provider, the written notice informs the member to submit a copy of the bill and documentation of payment to AmeriHealth Caritas VIP Care Plus and the Plan will reimburse the member for covered services.

# Who to Ask

- If you are not sure whether or not you may bill a member for services, contact AmeriHealth VIP Care Plus Provider Services at 1-888-667-0318.

- All providers are encouraged to utilize the AmeriHealth Caritas VIP Care Plus claims inquiry processes to resolve any outstanding claims payment issues.

# Quality Metrics

# Quality Assessment and Performance Improvement

AmeriHealth Caritas VIP Care Plus has a Quality Assessment and Performance Improvement (QAPI) Program to monitor the quality of services our members receive. In partnership with you, our network providers, we aim to make sure health care and services are:

- High quality
- Safe
- Appropriate
- Efficient
- Effective

We monitor the quality of care and services our members receive through a variety of methods, including metrics from the Healthcare Effectiveness Data and Information Set (HEDIS®).

- HEDIS is a registered trademark of the National Committee for Quality Assurance

We also use metrics from member surveys, including the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and the Health Outcomes Survey (HOS).

- CAHPS is a registered trademark of the Agency for Healthcare Research and Quality

# Key HEDIS Measures for our Members

- Breast Cancer Screening
- Colorectal Cancer Screening
- Comprehensive Diabetes Care
  - HgA1c Testing
  - HgA1c Control
  - BP Control
  - Eye Exam
  - Monitoring for Nephropathy
- Follow up within 30 Days of Inpatient Discharge
- Care for Older Adults
- Controlling Blood Pressure
- Medication Reconciliation Post-Discharge
- Adult BMI Assessment

# Ways You Can Help With HEDIS Reporting

- Submit claim/encounter data for each and every service rendered;
- Make sure that chart documentation reflects all services billed;
- Bill (or report by encounter submission) for all delivered services;
- Ensure that all claim/encounter data is submitted in an accurate and timely manner;
- Please consider including CPT II codes to provide additional details and reduce medical record requests.

****Submitting appropriate codes may decrease the need for us to request medical records to review for this information.****

# Care for Older Adults

Care for Older Adults (COA) includes a group of assessments intended to serve as additional preventive screenings for adults age 66 and over. AmeriHealth Caritas VIP Care Plus tracks these services as part of our ongoing HEDIS Quality Improvement Program:

- Advance care planning
- Pain assessment
- Functional assessment
- Medication review/list

AmeriHealth Caritas VIP Care Plus is able to assist providers in completing these assessments. These assessments are documented on a COA form and faxed to the PCP office. **The form must be filed in the member's medical record in order to satisfy the HEDIS requirement.**

# Care for Older Adults

Providers may also satisfy the COA requirement by completing the assessments and documenting them on a claim using the following codes:

| Code | Type | Measure | Description |
|---|---|---|---|
| **99497** | CPT | Advanced Care Directive | Advance care planning including the explanation and discussion of advance directives such as standard forms with completion of such forms when performed by the physician or other qualified health professional; first 30 minutes, face-to-face with patients, member(s), and/or surrogate. |
| **1157F** | CPT II | Advanced Care Directive | Advance care plan or similar legal document present in the medical record. |
| **1158F** | CPT II | Advanced Care Directive | Advance care planning discussion documented in the medical record. |
| **S0257** | HCPCS | Advanced Care Directive | Counseling and discussion regarding advance directives or end of life planning and decisions, with patient and/or surrogate. |
| **1123F** | CPT II | Advanced Care Directive | Advance care planning discussed and documented; advance care plan or surrogate decision maker document in the medial record. |
| **1124F** | CPT II | Advanced Care Directive | Advance care planning discussed and documented in the medical record, patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan. |
| **1159F** | CPT II | Medication Review | Medication list documented in medical record. |
| **1160F** | CPT II | Medication Review | Review of all medications by a prescribing practitioner or clinical pharmacist documented in the medical record. |
| **1170F** | CPT II | Functional Status Assessment | Functional status assessed. |
| **1125F** | CPT II | Pain Assessment | Pain severity quantified pain present. |
| **1126F** | CPT II | Pain Assessment | Pain severity quantified NO pain present. |

# Controlling Blood Pressure

This measure determines the percentage of members 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled (<140/90 mm Hg).

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

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

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

# Controlling Blood Pressure

Beginning in 2018, the HEDIS measure Controlling Blood Pressure can be reported using CPT II codes. Below are the CPT II codes that correspond to particular systolic and diastolic blood pressure measurements.

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

# Medication Reconciliation Post Discharge

Medication reconciliation post-discharge (MRP) is a review in which the discharge medications are reconciled with the most recent medication list in the outpatient record.

- Documentation must be in the outpatient medical record and include evidence of medication reconciliation; the date when it was performed by the prescribing practitioner, registered nurse or clinical pharmacist; and the provider signature.

Medication reconciliation post-discharge (MRP) can be reported with CPT Category II code 1111F. Or, if coding guidelines are met, MRP is reimbursed through two Transitional Care Management service codes 99495 and 99496:

The two TCM codes generally have the same requirements, with the primary difference being the level of decision-making involved, whether it is moderate or high complexity. In order to report these services the following must be met:

1. The **initial direct contact** with the patient and/or caregiver (includes telephone/electronic) must occur within **2 days** of discharge.
2. The patient **must be seen** within **7 days** of discharge (99495) for those with high complexity and within **14 days** of discharge (99496) for those with moderate complexity.
3. **Medication reconciliation** must be performed and documented within **30 days** of discharge. Other necessary follow-up, such as reviewing labs and scheduling additional services, should also be performed within the 30 days.

We realize not all patients discharged from the hospital require the complex decision making required by TCM services, however it is still important to perform MRP within 30 days. If you perform MRP without TCM, please document this service and submit claims using the appropriate CPT code.

# Adult BMI

An adult BMI assessment 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 |

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. If medical records are requested, a provider's documentation of BMI is only valid for HEDIS if the weight and BMI are from the same data source and are recorded in the medical record during the measurement year or year prior to the measurement year.

# CAHPS and HOS

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey and the Health Outcomes Survey (HOS) are administered annually to a random sample of our members.

The CAHPS survey asks consumers to evaluate their experiences with a wide range of health care services, through standardized questions that seek to assess the member's perception of their health plan experience.

The Health Outcomes Survey (HOS) assesses the ability of our plan to maintain or improve the physical and mental health of its enrollees over time.

Providers have an important role in the CAHPS survey and the HOS. To learn more about how you can help with the CAHPS survey and the HOS, additional information is available at http://www.amerihealthcaritasvipcareplus.com/assets/pdf/provider/resources/cahps-hos-flyer.pdf

# Influenza Vaccine

One of the questions within the CAHPS survey is specifically factored into the plan's HEDIS results. We ask for your help to ensure your patients receive the influenza vaccine. Your role in this effort is critical to help avert the considerable toll that influenza takes on the public's health each year.

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

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

# Influenza Vaccine

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

| Code | Labeler Name | Drug Name |
|---|---|---|
| 90653 | Seqirus Inc | Fluad (2020/2021) |
| 90694 | Seqirus Inc | Fluad Quadrivalent (2020/2021) |
| 90662 | Sanofi Pasteur | Fluzone High-Dose Quadrivalent (2020/2021) |
| 90672 | AstraZeneca/MedImmune | FluMist Quadrivalent (2020/2021) |
| 90674 | Seqirus Inc | Flucelvax Quadrivalent (2020/2021) (Pres Free) |
| 90682 | Sanofi Pasteur | Flublok Quadrivalent (2020/2021) |
| 90686 | GlaxoSmithKline<br>Sanofi Pasteur<br>Seqirus Inc | Fluarix Quadrivalent (2020/2021) (Pres Free) & Flulaval Quadrivalent (2020/2021) (Pres Free) Fluzone Quadrivalent (2020/2021) (Pres Free)<br>Afluria Quadrivalent (2020/2021) (Pres Free) |
| 90688 | Sanofi Pasteur<br>Seqirus Inc | Fluzone Quadrivalent (2020/2021)<br>Afluria Quadrivalent (2020/2021) |
| 90756 | Seqirus Inc | Flucelvax Quadrivalent (2020/2021) |

# HEDIS Rates from the HOS

Information used within HEDIS reporting is also collected from the HOS in a series of questions that ask members about information and care they receive from their health care providers.

Responses to questions are collected to derive the following four HEDIS measures:

- Management of Urinary Incontinence
  - Discussion, Treatment, Impact on Quality of Life
- Physical Activity in Older Adults
  - Discussion, Advising
- Falls Risk Management
  - Discussion, Management
- Osteoporosis Testing in Older Women

# Additional Information/Resources

AmeriHealth Caritas
VIP Care Plus

## What is risk adjustment?

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

# Why is risk adjustment done?

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

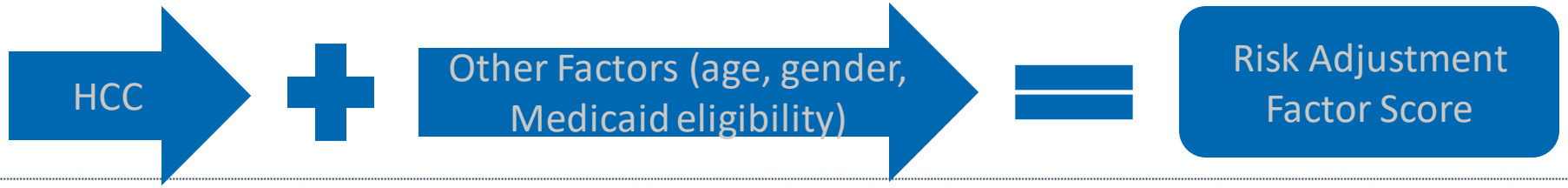
# What methodology is used for risk adjustment?

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

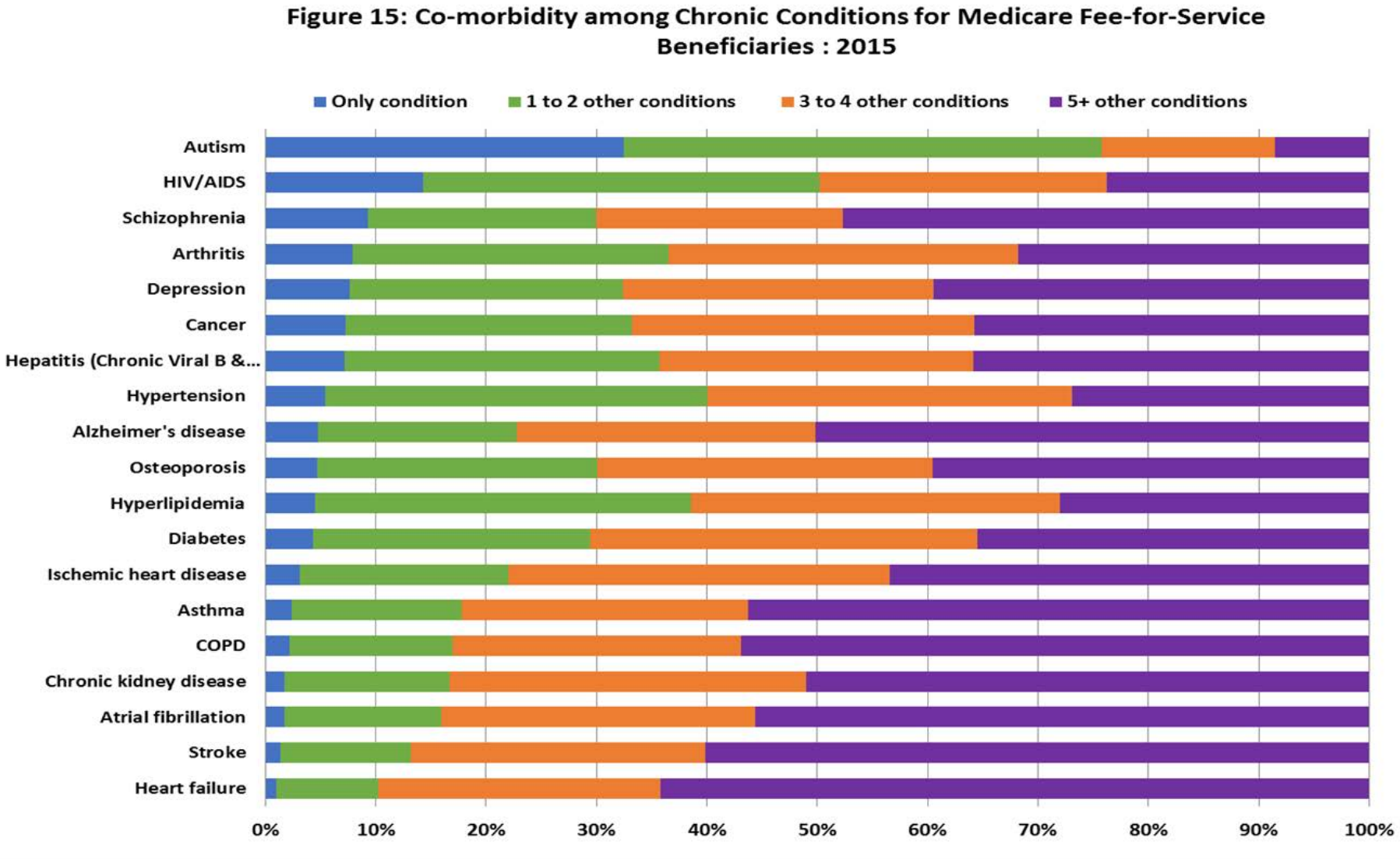
# Understanding Hierarchical Condition Categories (HCCs)

- Implemented by CMS in 2003.
- Measures the disease burden that includes 79 HCC categories, which are groups of clinically related diagnosis (ICD-10) codes with similar cost implications.
- The HCC model is made up of 10,000+ ICD-10 codes that typically represent costly, **chronic** diseases such as:
  - ✓ Diabetes
  - ✓ Chronic kidney disease
  - ✓ Congestive heart failure
  - ✓ Chronic obstructive pulmonary disease
  - ✓ Malignant neoplasms
  - ✓ Some acute conditions (MI, CVA, hip fracture)

- ICD 10 to HCC Crosswalk resource: https://www.nber.org/data/icd-hcc-crosswalk-icd-rxhcc-crosswalk.html



# Percent of Co-Morbidities




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

# How can this help beneficiaries?

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

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

# How can provider's help?

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

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

# How can provider's help (cont.)?

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

★ **Medicare Annual Wellness Visit** ★

# Risk Adjustment Data Validation (RADV) Audits

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

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

# Medicare Advantage Plans are Here to Stay

- 21.5 million Medicare beneficiaries are in a MA plan nationwide (34%)
- This number will increase over time, partly because MA plans:
  - Focus on preventive care and early intervention and are incentivized to provide high-value care to keep beneficiaries healthy and minimize disease progression.
  - Develop innovative models, such as care and disease management programs.
  - Address chronic diseases by encouraging providers to identify, manage, and treat chronic illness in innovative cost-effective ways, producing high-quality outcomes.
  - Experience a more clinically appropriate use of health care services than beneficiaries in Fee-for-Service (FFS) Medicare. For example, MA beneficiaries:
    - ✓ Experience lower incidence of emergency services, hospital admissions and readmissions, and receive fewer hip and knee replacements.
    - ✓ Are 20% more likely to have an annual preventive care visit, have improved PCP services and higher rates of screening and outcome metrics for chronic diseases.

# Why Risk Adjustment is Here to Stay

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

# Pharmacy - High Risk Drugs for the Elderly

## 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. AmeriHealth Caritas 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

# Report suspected fraud, waste or abuse to AmeriHealth Caritas VIP Care Plus

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

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

  AmeriHealth Caritas 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.**

# Reporting Abuse, Neglect and Exploitation

All AmeriHealth Caritas VIP Care Plus providers are required to identify, prevent and report abuse, neglect and exploitations of enrollees. As soon as a provider suspects that abuse is occurring, they are required to call the Michigan Department of Human Services Adult Protective Services. Michigan provides a statewide 24-Hour Hotline: 1-855-444-3911.

If you suspect abuse, neglect or exploitation of a resident of a nursing home by another resident or by a nursing home employee, notify:

- Bureau of Health Services Abuse Hotline: 1-800-882-6006
- Michigan Protection and Advocacy Service, Inc.:
  - Developmental Disabilities: 1-800-288-5923
  - Mental Illness: 1-800-288-5923
- Attorney General 24-hour Health Care Fraud Hotline: 1-800-24-ABUSE / 1-800-242-2873

Providers are also required to alert the AmeriHealth Caritas VIP Care Plus Case Manager within 24 hours of making a report to Adult Protective Services.

# Americans with Disabilities Act (ADA)

As a plan participating in the MI Health Link Medicare-Medicaid program, we must provide our members with access to all covered medical services and essential health benefits. We are required to reasonably accommodate members and ensure programs and services are as accessible (including physical and geographic access) to individuals with disabilities as they are to individuals without disabilities. Accordingly, we will inform members in the provider directory of a provider's ability to accommodate special needs.

# Americans with Disabilities Act (ADA) Attestation

AmeriHealth Caritas VIP Care Plus asks that providers complete an assessment for each physical practice location to ensure we are providing AmeriHealth Caritas VIP Care Plus members with the most accurate information regarding your practice. You may complete the survey on our website under the Providers > Self-Service Tools > Americans with Disabilities Act (ADA) Attestation in the following ways:

- Online survey
- Fillable PDF which can be sent to the following:
  - E-mail PDF to: MichiganProviderNetwork@amerihealthcaritas.com or
  - Fax to: 1-855-306-9762

# Disability Competency Training for Medical, Behavioral, Pharmacy and LTSS Providers

AmeriHealth Caritas
VIP Care Plus

# What is a Disability?

Disability is the consequence of an impairment that may be:

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

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

# The Disability Experience

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

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

This population is:

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

## People with disabilities are more likely to:

- Experience difficulties or delays in getting the health care they need
- Not have had an annual dental visit
- Not have had a mammogram in the past 2 years
- Not have had a Pap test within the past 3 years
- Not engage in fitness activities
- Have high blood pressure

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

# The Healthcare of Individuals with Disabilities

Care is at times:

- -Reactive
- -Fragmented
- -Inaccessible
- -Standardized / uniform

Resulting in:

- -Avoidable costs, both human and financial
- -Misaligned incentives, leading to increasing costs
- -Ineffective or nonexistent primary care

# Disability Competent Care and Providers

Providers of health care should understand the member's:

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

# The AmeriHealth Caritas VIP Care Plus Member Rights

AmeriHealth Caritas VIP Care Plus Members all need and expect:

-Right care

-Right place

-Right time

These rights are achieved by providing:

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

Awareness - Awareness of specific services.

Access to Care - Ability to access available care.

# AmeriHealth Caritas VIP Care Plus Primary Care Requirements

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

- ✓ Enhanced primary care with flexible and extended hours that will assist members in accessing care.
- ✓ 24/7 urgent and emergent care for members.
- ✓ Access to informed and knowledgeable clinicians with electronic health records capability.
- ✓ Focus on early intervention to prevent complication or exacerbation of chronic conditions.
- ✓ Active participation in the Multi Disciplinary Team with aggressive transition planning and follow-up.
- ✓ Accessible physical facilities, with essential adaptive equipment and flexible scheduling.

# Barriers for the Members with Disabilities

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

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

# Without Appropriate Accessibility

Members with disabilities can experience:

-Frustration

-Fatigue

-Failure

-Fear

Poor Quality:

-Lack of care

-Delayed diagnosis

-Deteriorating health

# Attitude - The Social Model of Disability

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

Providers need to be aware of their "ableism":

-Ingrained perceptions which can affect interactions

-Impact the care offered or provided

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

# Attitude

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

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

# Attitude - Allowing it to Affect the Member

“There is no reason for someone like you to be tested for AIDS.”

“But this is an ambulatory care clinic.”

“My, aren’t you cute.”

“It’s best you not have children.”

“You don’t have to worry about osteoporosis since you can’t walk.”

“Getting a mammogram is hard for you, so you can just skip it.”

## Two aspects of communication:

1. Engagement and listening
2. Using the right auxiliary aids and services to accommodate patients with the following limitations:
    - Hearing
    - Sight
    - Comprehension

# Communication

Usable formats:

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

# Communicating Effectively

Examples of effective directions when prescribing:

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

Regularly utilize teach-back techniques to help ensure our members and your patients understand their prescription instructions.

# Communicating Effectively - What is CLAS?

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

**Title VI of the Civil Rights Act of 1964:**

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

**Office of Minority Health's National CLAS Standards:**

Organized into 4 categories:

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

# AmeriHealth Caritas VIP Care Plus CLAS Program

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

# Interpretation Services


Call Provider/Member Services 1-888-667-0318 OR

the 24 Hour Nurse Help Line 1-855-843-1145 to be connected.

## Office Location Accessibility

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

# Physical Barriers to Care / Equipment Access

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

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

# Physical Barriers to Care / Equipment Access

## Pay attention to potential barriers in the delivery of care:

- Accessible Exam Rooms
  - Entry Doors
  - Clear Floor and Turning Space
- Adjustable and Accessible Exam Tables
- Transferring Equipment
- Accessible Scales
- Accessible Radiological and Mammography Devices

# Physical Barriers to Care / Equipment Access

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

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

# Physical Barriers - Accommodating the Members with Disabilities

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

Examples include:

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

# Reviews of Provider Offices

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

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

*Gynecology had the highest rate of inaccessibility for members.*

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

# Navigating the Healthcare Setting

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

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

# Behavioral Health Barriers

Common behavioral health barriers:

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

# Behavioral Health Crisis Prevention

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

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

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

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

# DO:

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

# Behavioral Health Crisis Treatment

DO NOT:

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

# Behavioral Health – Post Crisis

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

# Person-Centered Planning

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

# Self-Determination

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

# Independent Living Philosophy

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

# Guiding Principles of the Recovery Model

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

# Guiding Principles of the Recovery Model

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

# Common Questions and Answers

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

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

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

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

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

# Common Questions and Answers

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

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

# Common Questions and Answers

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

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

# Common Questions and Answers

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

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

# Common Questions and Answers

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

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

# Common Questions and Answers

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

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

# Conclusion

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

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

Real access is not just installation!

AmeriHealth Caritas™

VIP Care Plus