First Choice VIP Care PLUS

A Healthy Connections Prime Medicare-Medicaid Plan

FirstChoice VIP CARE PLUS by Select Health of South Carolina

Healthy Connections PRIME

What is Healthy Connections Prime?

Healthy Connections Prime is a demonstration (pilot) program which started in February 2015 for seniors with both Medicare and South Carolina Healthy Connections Medicaid. South Carolina 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 through a care team and a care manager that works directly with the member and their doctors.

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

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:

- 65 and older
- Fully eligible for Medicare parts A, B, and D
- Fully eligible for Medicaid
- Meet the above criteria and are enrolled in the Community Choices, HIV/AIDS, or Mechanical Ventilator Dependent Waiver Programs

Individuals are ineligible if they are:

- Under Hospice care at the time of eligibility
- Receiving treatment for End Stage Renal Disease (ESRD)
- Institutionalized in a nursing facility or other institution at the time of eligibility

How many members are eligible for Healthy Connections Prime?

Estimates are that approximately 62,500 persons age 65 and older in our state are currently eligible to enroll in the program.

How is this different than traditional Medicare and Medicaid?

How is this different?

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

Current Services	New Benefits
✓ Doctor visits	✓ One plan
✓ Hospital care	✓ One card
✓ Medicare Part D and other medications covered by Healthy Connections Medicaid	✓ One number to call
✓ Adult dental*	✓ No insurance premiums, no costs for doctor visits and hospital stays
✓ Durable Medical Equipment (DME)	✓ A care team
✓ Emergency and Medicaid Transportation Services*	✓ A personalized care plan that fits your needs
✓ Nursing Home and Community Long-Term Care (CLTC)	✓ Help transitioning home from the hospital or nursing home
	✓ The right care, at the right time, in the right place

**These services are still covered and available for you under Healthy Connections Medicaid.*

Plan Roll-out Timeline

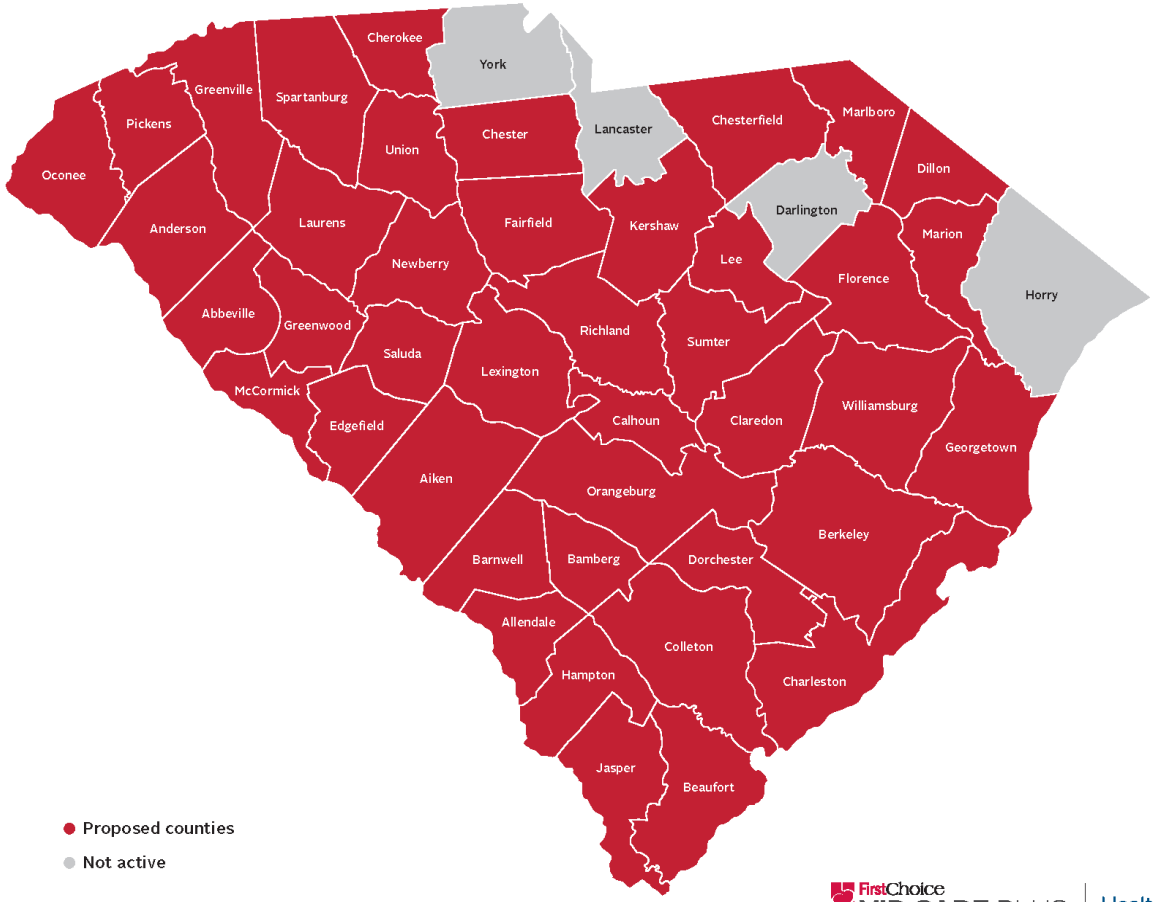
Healthy Connections Prime Enrollment Timeline

Marketing Began	12/1/14
Voluntary Opt-In Effective Date	2/1/15
Passive Enrollment – Wave 1 (Upstate)	4/1/16
Passive Enrollment including HCBS Population – Wave 2 (Coastal Region)	7/1/16
Passive Enrollment – Advicare Transition	9/1/16 and 11/1/16
Passive Enrollment – Wave 3 (Entire State)	8/1/17
Passive Enrollment – Ongoing	Starting 9/1/17
Expanded Passive Enrollment	1/1/19

Why Select Health and Healthy Connections Prime?

- Select Health has worked with South Carolina Department of Health and Human services as a managed care Medicaid since 1995.
- Select Health currently covers over 350,000 South Carolina residents statewide.
- Select Health was awarded a contract to be one of four (now three) Coordinated and Integrated Care Organizations (CICO) in the Healthy Connections Prime program.

First Choice VIP Care PLUS Service Area



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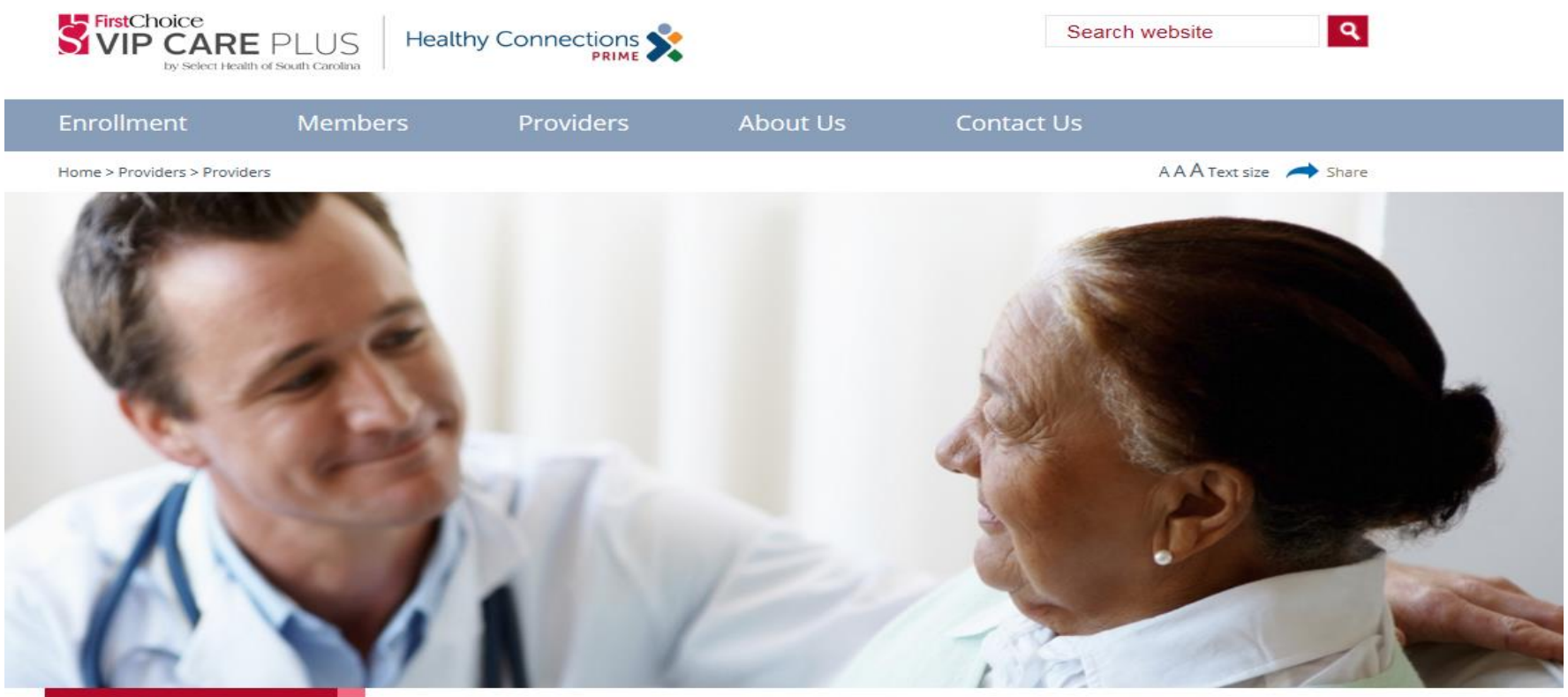
Provider Resources

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

First Choice VIP Care 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.firstchoicevipcareplus.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 First Choice 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 1-888-978-0862.

Model of Care
(MOC)

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

Model of Care Annual Training Requirement

As a Medicare-Medicaid Plan, First Choice 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.firstchoicevipcareplus.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

Model of Care — Why First Choice VIP Care PLUS Was Created

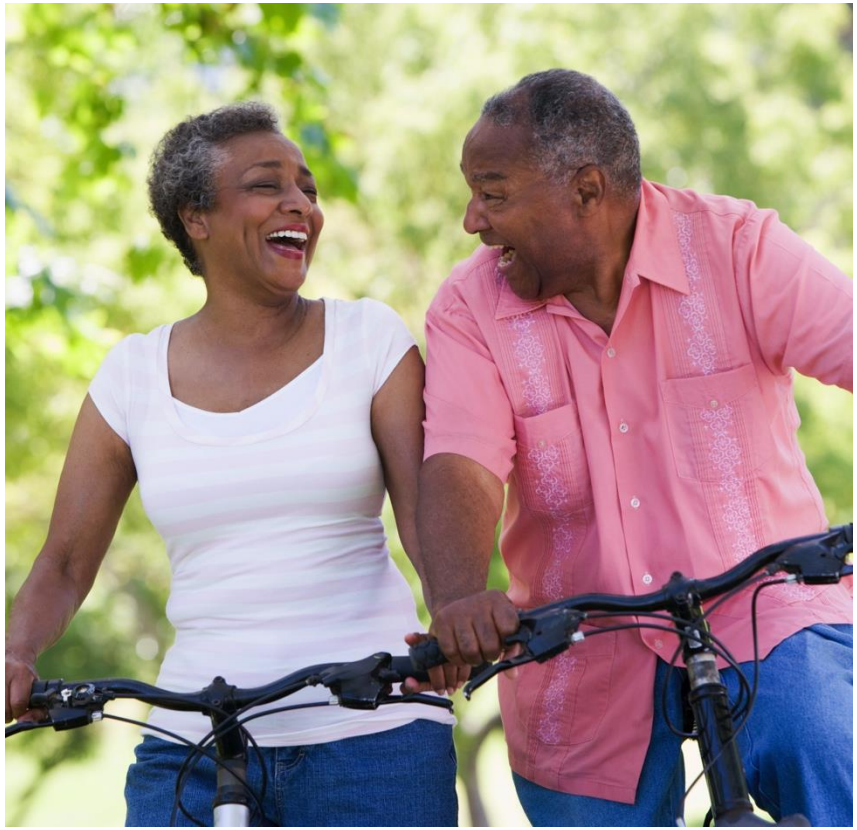
The First Choice VIP Care Plus plan was created to offer Medicare and Healthy Connections Medicaid eligible beneficiaries the opportunity to receive coordinated benefits and efficiently and effectively manage their care.

The goals of creating this plan are to:

- Improve health outcomes
- Keep beneficiaries in the community
- Simplify the delivery system and align payments 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 First Choice VIP Care Plus's

Model of how we **Care** for our Dual Eligible members.

Why the Model of Care is Necessary

- 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

Model of Care - How Medicare-Medicaid (Dual) Eligibles Are Different from the General Medicare Population

They are:

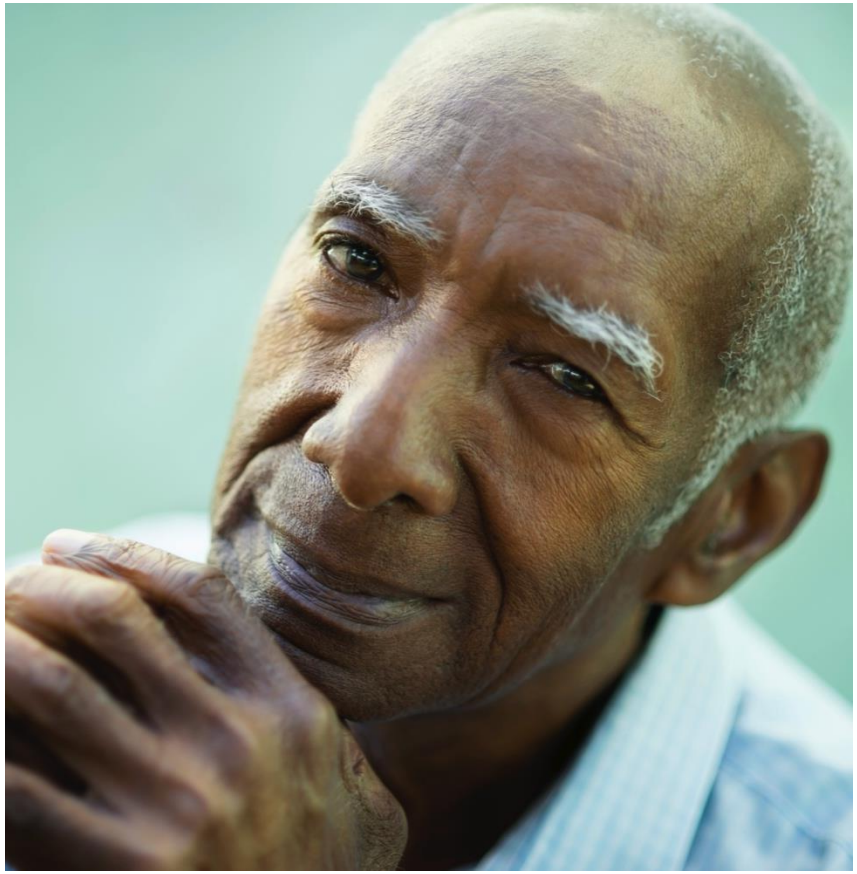
- Three times more likely to live with a disabling condition.
- More likely to have greater limitations in activities of daily living (ADLs), such as bathing and dressing.
- More likely to suffer from cognitive impairment and mental disorders.
- Indicated to have higher rates of pulmonary disease, diabetes, 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.

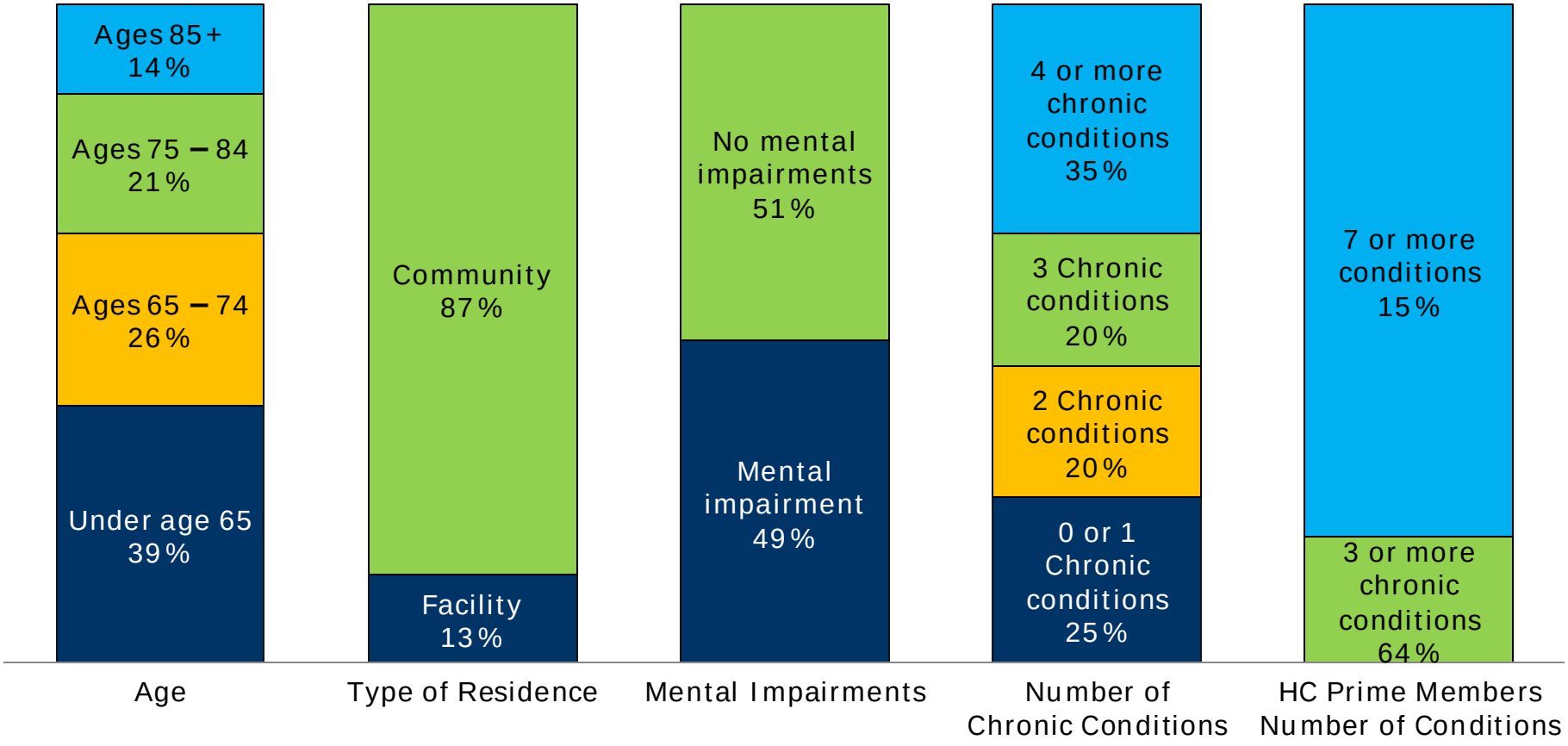
Model of Care — Outlining the High Volume = High-Cost Issue in the Dual-Eligible Population

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

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



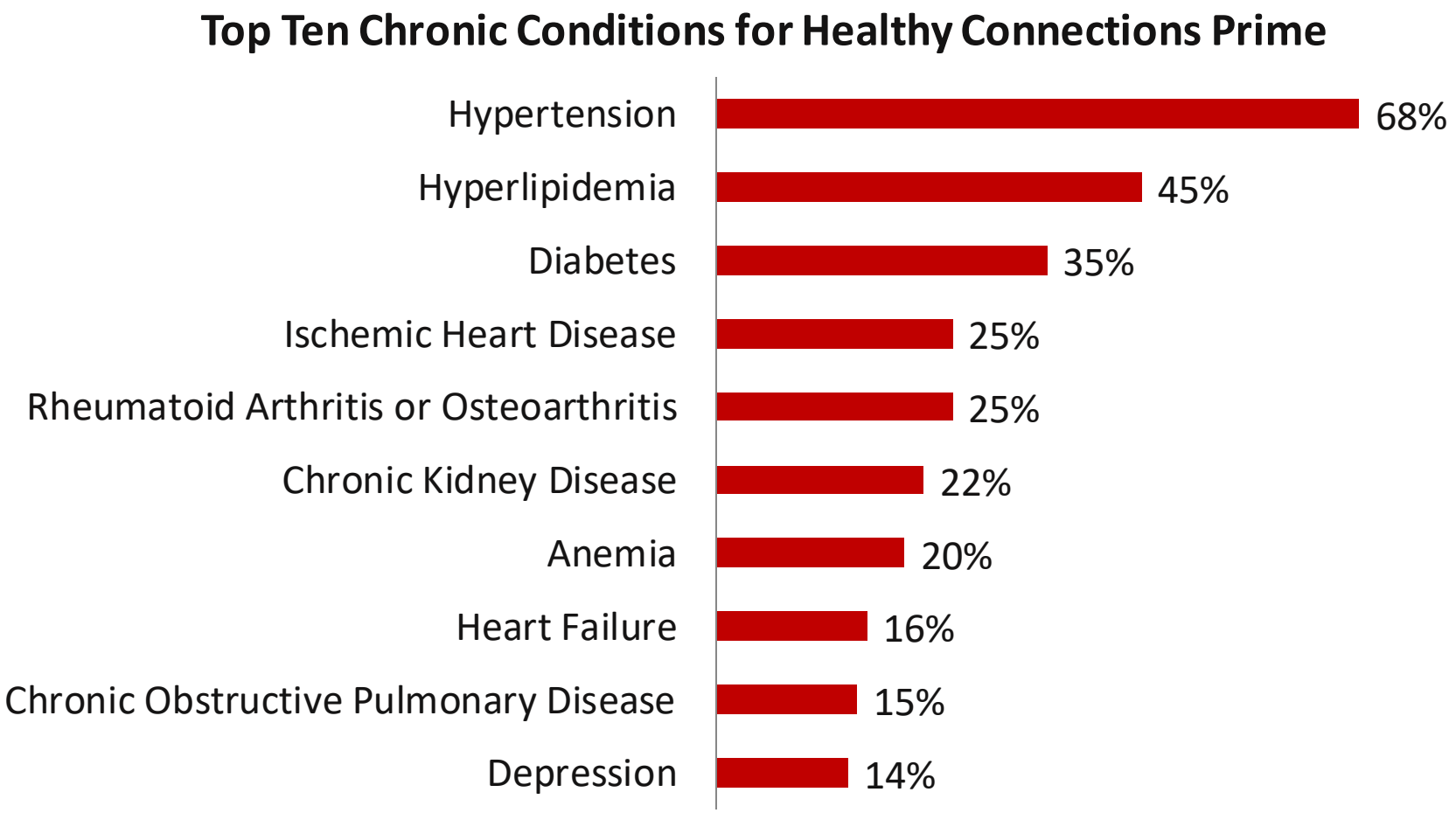
Model of Care — Why Dual Eligibles Are Special-Needs Members



Note: **Mental impairments were defined as Alzheimer's disease, dementia,** depression, bipolar disorder, schizophrenia or intellectual disabilities.

Source: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey, 2008.

Top Ten Chronic Conditions for Healthy Connections Prime



Building the Model of Care Multidisciplinary Team (MT)

An integral part of the MOC is building a MT. This begins with the development of a First Choice 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 First Choice VIP Care Plus Care Team includes:

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

First Choice VIP Care PLUS Care Team Roles & Responsibilities

Personal Care Connectors

All Customer Service Functions

Welcome Calls

Provider Lookup / PCP Assignments

Quoting Benefits

Screening Questions
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 the Care Team Help Members

The 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 Multidisciplinary Team (MT)

The Care Team alone cannot help the member reach their goals of the person-centered planning approach. The MT is crafted to help support the individual goals/needs of each member and is completed by including the following, if applicable:

- The member
- The primary care provider or medical home
- Health plan nurses, medical directors and pharmacists
- Physical and behavioral health specialists
- Long Term Services and Supports (LTSS) providers
- Social workers
- Community mental health workers
- Physical, speech and occupational therapy providers
- Others who play an important role in their care - family members, friends, pastor, etc.

Working Together

Collaboration between all members of the multidisciplinary 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

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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 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 Assess for knowledge regarding injury and rehabilitation. 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

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 Home Diversion

When the Care Coordinator (CC) first met the member, he was living with his daughter, wheelchair-bound for over a year, and was alone most of the time. The member had difficultly being transferred from his chair to his wheelchair and fell several times, and after the member's grandson moved out in June 2017, his daughter began to actively and aggressively look for nursing home placement. The member's daughter felt that it was the only possible option for the member since she and her spouse worked long hours. A referral was made to Community Long-Term Care (CLTC) for waiver services, but the daughter kept insisting that she wanted the member to be moved to a nursing home as soon as possible.

The member was hospitalized in October 2017 and then transferred to a skilled nursing facility. The daughter's plan at that time was for him to move to custodial care upon completion of his skilled nursing facility stay. She didn't want the member to return to her home. The member was very sad about all of this and would cry about having to go to a nursing home. The CC worked closely with CLTC and they spoke with the member's adult son. A plan was eventually reached for the member to go and live with the son and his wife. The member is now living with his son and receiving waiver services. Both the CC and Community Health Navigator (CHN) visited the member and they found that the member's son and his wife are taking great care of the member and they observed that the member is extremely happy. It was the first time in over a year that the CC saw the member smile. The member is optimistic and determined to stay out of the hospital. He has started walking daily with the help of his son and received an electric wheelchair so he is able to get outside more.

Success Story – Finding a Hard to Reach Member

A member was hard to reach for 2 years and in June 2018 she was hospitalized. The CC was able to use information in the hospital records to locate the member. The CC made a blind visit, and was eventually able to schedule a visit to conduct the initial assessments. The member was found to be declining in mental status, very forgetful, often confused, refusing to bathe for weeks, hiding her medications and forgetting where they were, or putting all of her pills in one bottle. She was eating very poorly and had lost over 10% of her body weight in the past year. In addition, three adult daughters were not getting along and unable to agree on the care of the member. She was living alone with one daughter next door.

The CC made a referral for CLTC services and contacted the PCP about concerns for the member's safety. One daughter reportedly gave her a large dose of laxatives a few weeks later and she had to go to the ER for treatment for dehydration. After that the CC went by the PCP office to inform him, again, of her concerns because he reportedly had told the family that the member was fine and could live alone. After that, the member was taken to the home of the daughter who has Power of Attorney. The CC requested flexible benefits because the daughter works 7 days/week. As of 11/12/2018, member is receiving care from a Personal Care Assistant 7 hours/day, 7days/week. The daughter is administering medications correctly. The member's daughter is also planning to follow up with care gaps for the member.

Success Stories – Finding Extra Help for Members

- A CHN was unable to reach a member by phone so she drove nearly 70 miles to her home and knocked on her door. The member welcomed the CHN into her home, and accepted her offer to help. She had not visited a doctor for four years and didn't have a phone where she lived. The member said her knees hurt and she agreed to go to a doctor. The CHN worked with the member to select a PCP and scheduled an appointment. The CHN attended the appointment with her. During her visit, the CHN discovered the member had more than $1,000 in overdue electric utility bills and her water heater was not functioning properly. The CHN was able to find a resource to have the electricity bill paid, and she got the landlord to install a new water heater.
- During a home visit to perform a reassessment, our CC discovered that one of our members who is blind and lives alone did not have a working smoke detector in her home. Concerned for the member's safety, the CC reached out to the CHN for assistance. The CHN reached out to a local Fire Department and was able to obtain a working smoke detector and a bed shaker for the member.

Success Story – Finding Extra Help for Members

- During a home visit, the CC noticed that a member's home was in need of some minor repairs and yard clean up. Every summer the United Way provides home repairs for seniors in the area. The CC made a referral on the member's behalf and the member's name was chosen. With the help of United Way and the Methodist Church, the member's entire home was painted, new screens doors were installed, and old trees and shrubs left behind by Hurricanes Harvey and Irma were removed.
- Spanish speaking member has been diagnosed with breast cancer. Her provider explained she needed chemotherapy, but the member is hesitant and doesn't want to start treatment. The plan's bilingual CHN spoke with member to explain the importance of her treatment and to help ease the member's concerns. The member expressed interest in going to a cancer support group to get more information that would help her make a decision about chemotherapy. Due to the fact that the member only speaks Spanish, the CHN agreed to accompany the member to the support group class to assist her with translations and to provide support.

Success Story - Resolving Gaps in Care

One of our Community Health Navigators (CHN) was following up on a member and identified it had been several months since the member picked up a prescription for his chronic condition. The CHN called the member and encouraged him to follow up with his PCP to get the prescriptions. After the appointment was scheduled, the CHN met with the member for the appointment. Care gaps were discussed with the doctor. The member received his pneumonia vaccination, planned to get the flu vaccination at the pharmacy, and he picked up his prescriptions at the pharmacy.

The CHN also helped the member to set up transportation services, enrolled the member with the mail order program, and assisted him in completing the free phone application. Transportation and memory issues are the reasons why the member did not follow up with his PCP appointment and why his prescriptions had not been filled. T he member appreciated receiving the assistance and is now better prepared for maintaining and improving his health status.

Success Story - Finding a safe and convenient home

We have a member that really trusts our services and any time he needs help he reaches out to his Care Coordinator and Community Health Navigator (Care Team). In the past, the member's care team assisted him with the application process for housing and the member was overjoyed when he was approved for an apartment located on the second floor.

The member was recently diagnosed with lung cancer and, now that his health has declined, the member reached out to his care team and advised them that he needed to be moved to the first floor. The member's Care Team assisted the member with getting a letter from his doctor and they also talked to the Housing Authority to inform them about the member's urgent need to move. Today, the member is living at the same facility but now has an apartment on the first floor. With the help of his Care Team, the member is in a safe and convenient apartment on the first floor that is better suited for his medical condition as he no longer has to walk a flight of stairs to the second floor. The member has also been referred to the waiver program and will begin to receive Flex Benefits via our supplemental program until his waiver application is approved.

SC Healthy Connections Prime Successes

First Choice VIP Care Plus is one of the top 5 Medicare-Medicaid plans in the United States in Member Satisfaction, tying for 1st place with three other plans with a score of 90%.

2016 Assessment and Care Plans Completed within 90-Days of Enrollment		
Metric	South Carolina	Demonstration National Average
Comprehensive Assessments	94.5%	89.5%
Care Plans	83.8%	70.6%

2016 Emergency Room and Hospital Discharge Follow Up		
Metric	South Carolina	Demonstration National Average
Behavioral Health-Related Emergency Room Visits, Annual Visits / 10,000 Member Months	19.8%	38.6%
Percent of Hospital Discharges with an Ambulatory Care Follow-Up Visit Within 30 Days After Hospital Discharge	77.4%	71.1%

Transitional Care Planning – Continuity of Care

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Continuity of Care

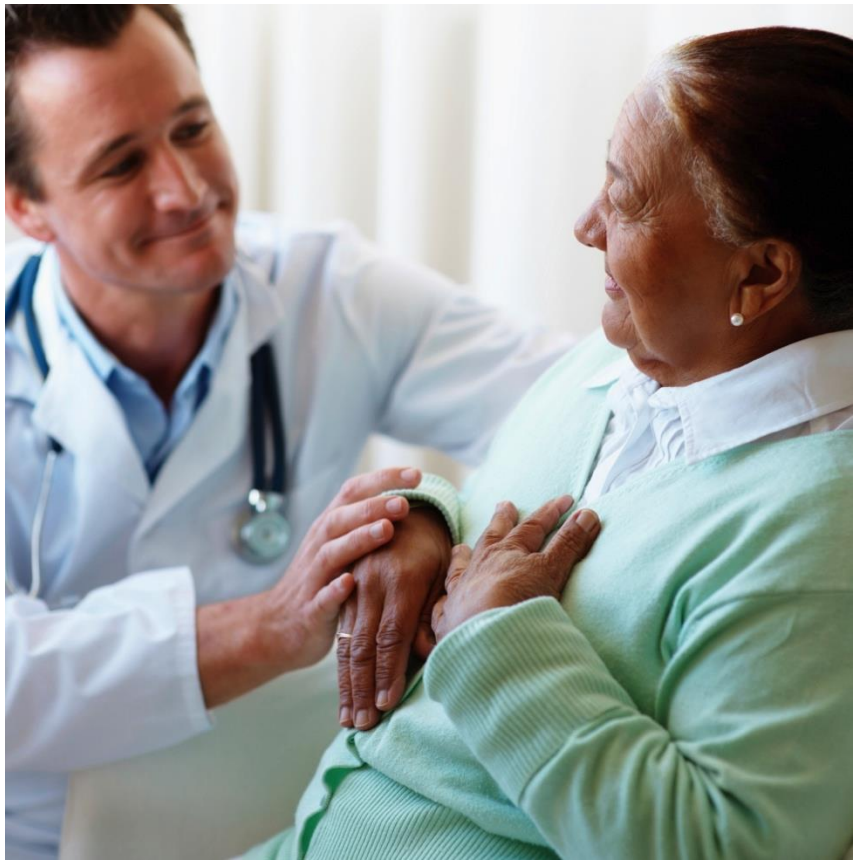
This program has been designed to provide seniors with coordination of their care, including long term care needs.

- 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 Healthy Connections Prime.
- Given the vulnerability of this member population, First Choice 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

First Choice 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, First Choice VIP Care Plus may offer providers single case agreements to continue a member's care after the 180-day transition period ends.

Please note – If a provider is already credentialed with First Choice, no additional credentialing paperwork is required for First Choice VIP Care Plus. However, a separate contract is required for participation.

First Choice VIP Care PLUS MMP Benefits

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

First Choice VIP Care PLUS covers all

Original Medicare and Healthy Connections Medicaid Medical Benefits

- Medicare Parts A and B benefits
- Medicare Part D prescription drug benefits
- Healthy Connections Medicaid benefits
- Long Term Services and Supports (LTSS) benefits for the:
  - Community Choices Waiver
  - HIV/AIDS Waiver and
  - Mechanical Ventilator Dependent Waiver
- Supplemental benefits

First Choice VIP Care Plus **does not** charge deductible, coinsurance, or a copayment for Original Medicare and Healthy Connections Medicaid medical benefits to the member, except for some Medicaid-only covered services.

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

PLAN NAME	MEDICARE PARTS A & B	MEDICARE PART D	HEALTHY CONNECTIONS MEDICAID
Medicaid South Carolina Department of Health and Human Services	NA	NA	✓
Medicare Fee for Service or Medicare Advantage (MAPD)	✓	✓	Not applicable for non-dual Medicare beneficiaries FFS for dual eligible beneficiaries
First Choice VIP Care Plus 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 * **

- Adult Day Health Transportation
- Skilled Nursing Facility
- Home Health Services
- Durable Medical Equipment
- Prosthetics/Medical Supplies
- Family Planning
- Personal Care Services (Personal Care I and II)
- Private Duty Nursing
- Institution for Mental Disease
- Pharmacy Services
- Dialysis for End-Stage Renal Disease (ESRD)
- Medicaid Targeted Case Management
- Health Education
- Behavioral Health Services (Rehabilitative Behavioral Health)
- Outpatient Mental Health Services (Community mental health services)
- Infusion Centers/Services
- Nursing Home Transition Services (Home Again)
- Tele-psychiatry

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

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

Supplemental and Carved Out Benefits

Supplemental Benefits:

- Routine vision exams and materials
- Routine hearing exams and hearing aids
- 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 Medicaid Fee for Service:

- Non-Emergency Medical Transportation Services
- Adult Dental

Covered by Medicare Fee for Service:

- Hospice Services

Long Term Services and Supports (LTSS) Benefits

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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 the state specific Medicaid programs that allow for long term services and supports to be provided outside of nursing homes. Waivers may also be referred to as:

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

Healthy Connections Prime will include three of the nine South Carolina waiver programs: Community Choices, HIV/AIDS, and Mechanical Ventilator Dependent waivers.

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 states to use the same funds to provide these supports and services for people in their homes or in their own communities.

- Adult Day Health Care
- Case Management
- Personal Care (I and II)
- Adult Care Home Services
- Adult Companion Care
- Adult Day Health Care Transportation
- Attendant Care
- Community Residential Personal Assistance (CRPA)
- Home Accessibility Adaptations
- Home delivered meals
- Nursing Home Transition Service
- Personal Emergency Response System
- Specialized Medical Equipment and Supplies
- Telemonitoring

Benefits – Community Choices Waiver

Benefits-HIV/Aids Waiver

- Case Management
- Personal Care (I and II)
- Prescription Drugs, except drugs furnished to participants who are eligible for Medicare Part D benefits
- Adult Companion Care
- Attendant Care Services
- Home Accessibility Adaptations
- Home Delivered Meals
- Private Duty Nursing
- Specialized Medical Equipment and Supplies

- Personal Care (I and II)
- Respite
- Prescription Drugs, except drugs furnished to participants who are eligible for Medicare Part D benefits
- Attendant Care
- Home Accessibility Adaptations
- Personal Emergency Response System
- Pest Control
- Private Duty Nursing
- Specialized Medical Equipment and Supplies

Benefits- Mechanical Ventilator Dependent Waiver

Other Benefits/ Services

- Incontinence Supplies
- Oral Nutritional Supplements
- Miscellaneous Supplies and Equipment
- “Flexible Benefits” - members who are in the application process for one of the three (3) waiver programs listed above may be eligible for “waiver-like” services during that time period, if the First Choice VIP Care Plus Care Coordinator determines that the services are necessary to avoid or delay nursing home placement as identified through an assessment conducted by the care coordinator or by physician recommendation/order.
- Members referred by First Choice VIP Care Plus and accepted in to a waiver program will not be placed on a waiting list.

First Choice VIP Care Plus will refer members to local resources for services that are not covered by First Choice VIP Care Plus, such as supportive, affordable housing and other social services that maximize community integration, as appropriate. Providers may contact the First Choice VIP Care Plus Care Management team at 1-888-244-5440 for assistance with coordination of non-covered services.

Non-covered Benefits / Services

Benefits – 24/7/365 Nurse Line

If members are unable to reach their PCP's office, registered nurses are available 24/7 to assist members through the toll-free Nurse Call Line.

First Choice VIP Care Nurse Call Line: 1-855-843-1147

Please encourage our members to take advantage of this option.

Interpretation Services

Free language services for First Choice VIP Care Plus members anywhere, anytime.

Call Provider/Member Services at 1-888-978-0862

OR

the 24 Hour Nurse Help Line at 1-855-843-1147 to be connected.

First Choice VIP Care PLUS Member Eligibility

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

Member Eligibility – Helpful Tips

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

- First Choice VIP Care Plus covers both traditional Medicare and Healthy Connections Medicaid Services.
- Members in an MMP can change plans each month.
  - Ensure that plan requirements are met. (Prior Authorizations)
  - Reduce claim issues because you are sending claims to the right plan.
- Verify eligibility before each visit.
- Make sure the the correct primary care physician (PCP) is listed on the member's identification card.
- Call Provider Services at 1-888-978-0862 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 1-888-978-0862.
- NaviNet.
- SCDHHS web portal available through https://portal.scmedicaid.com/login. Result will show:
  - Healthy Connections Prime
  - Which CICO they are enrolled with
- 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 Healthy Connections Prime plans should contact South Carolina Healthy Connections Choices at:

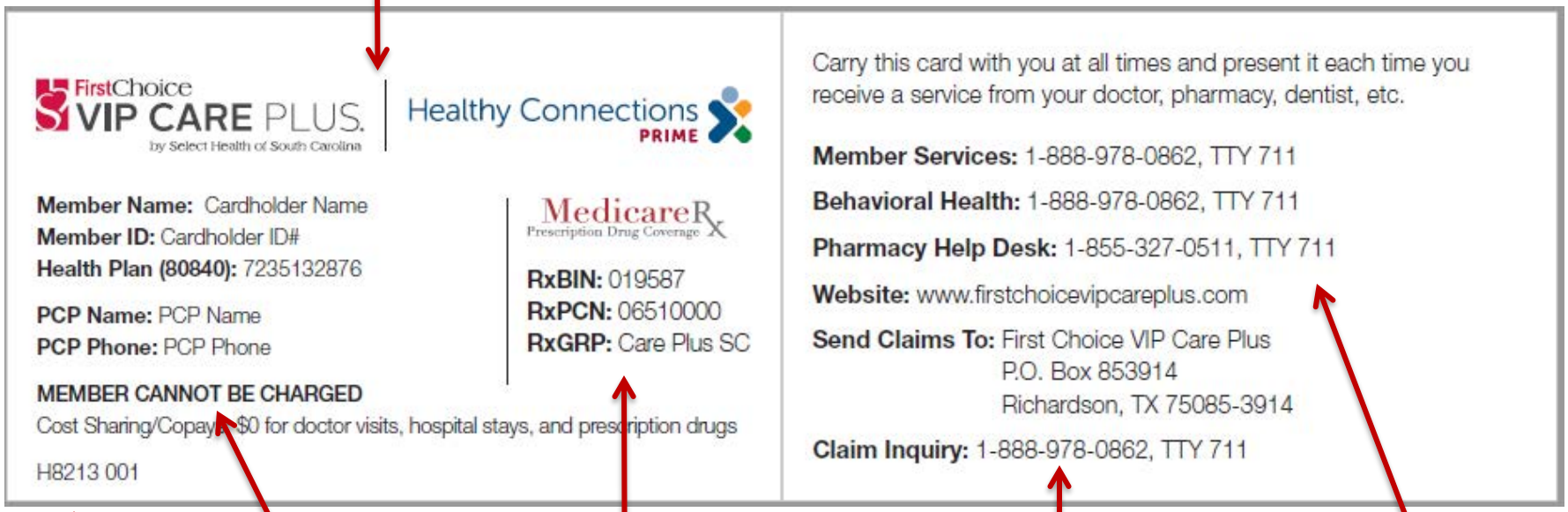
- 1-877-552-4642 to speak with an enrollment counselor Monday through Friday from 8 a.m. - 6 p.m.
- TTY users should call 1-877-552-4670 or 711.

If individuals who want to enroll have questions they can:

- Call the plan they are interested in directly.
- Call SC Thrive at 1-800-726-8774 (TTY 711), Monday-Friday, 8:30 a.m. - 5 p.m. to schedule an education session.

The plans have no ability to enroll or dis-enroll individuals.

Member Eligibility – Member ID Card



Medicare-Medicaid Plan Information

CMS Contract Number

No Balance Billing Statement

Prescription Drug Information

Claims Contact Information

Pharmacy Information

Access to Care Standards

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

Healthy Connections Prime Requirements

CMS and SCDHHS mandated requirements of all CICOs for access to care requirements.

The following access to care standards are applicable to all providers contracted with a CICO for Healthy Connections Prime.

Physical Health Access to Care Requirements

Primary Care Physician (PCP)	**Emergency Care**	**Twenty-four (24) hours per day, seven (7) days per week**
	Urgent, Symptomatic Care	Forty-eight (48) hours
	Non-Urgent, Symptomatic Care	Ten (10) calendar days
	Non-Symptomatic (Well or Preventive) Care	Four (4) to six (6) weeks
	Medical Follow-Up to Inpatient Care	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	Thirty (30) calendar days

Behavioral Health Access to Care Requirements

Life Threatening Emergencies ***Definition of Life Threatening Emergency:*** A situation requiring immediate care to a Member to prevent death, serious injury or deformity of the Member.	Providers must ensure that Members receive an appointment within **one (1) hour** of the request for services.
Non-Life Threatening Emergencies ***Definition of Non-Life Threatening Emergency:*** A behavioral health condition where the Member may suffer significant physical or emotional deterioration resulting in hospitalization or partial hospitalization unless an intervention is made within **six (6) hours**.	Provider must ensure that Members receive an appointment within **six (6) hours** of the request for services.

Behavioral Health Access to Care Requirements

Urgent ***Definition of Urgent:*** **The diagnosis and treatment of medical conditions that are serious or acute but pose no immediate threat to life and health, but which require medical attention within twenty four (24) hours.**	Providers must ensure that Members receive an appointment within **twenty-four (24) hours** of the request for services.
Routine Mental Health Services ***Definition of Routine:*** Routine services are those services not deemed emergent or urgent.	Provider must ensure that Members receive an appointment within **twenty-one (21) business days** of the request for services.
Waiting Time in a Provider Office	Not to exceed forty-five (45) minutes
Use of Free Interpreter Services	As needed upon member request during all appointments

Prior Authorization- Organization Determination

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

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 Multidisciplinary 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:

- Prior Authorization Line: 1-888-244-5410
- Fax: 1-888-257-7960
- NaviNet: www.firstchoicevipcareplus.com or www.navinet.net

Prior Authorizations - Time Frames

- First Choice 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.
- First Choice VIP Care Plus has seventy-two (72) hours to complete an expedited request.
- Once an authorization is processed, the First Choice 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 First Choice 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 First Choice VIP Care Plus Provider Manual or the Provider section on the First Choice 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

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

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:

Notice of Denial Continued

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

You have the right to ask First Choice VIP Care Plus to review our decision by asking us for a Level 1 Appeal.

Ask First Choice VIP Care Plus for a Level 1 Appeal within **60 days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline.

If we're stopping or reducing a service, you can keep getting the service while your case is being reviewed. ***If you want the service to continue, you must ask for an appeal within 10 days*** *of the date of this notice or before the service is stopped or reduced, whichever is later. Your provider must agree that you should continue getting the service. If you lose your appeal, you may have to pay for these services.*

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

- Elective/non-emergent air ambulance transportation
- All out-of-network service (excluding emergency services)
- Inpatient services
- Certain outpatient diagnostic tests
- Home health services
- Therapy and related services
- Transplants, including transplant evaluations
- Certain durable medical equipment (DME)
- Religious nonmedical health care institutions
- Hyperbaric oxygen
- Surgery
- Surgical services
- 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 authorization, please refer to the Provider Manual or call Care Management.**

Member Appeals

Members, their authorized representative, including providers, may file appeals with First Choice VIP Care Plus:

- Initial appeals must be filed with First Choice 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 a State Fair Hearing and must be initiated by the member.
- Next level appeals for benefits that overlap will first go to the IRE then to a State Fair Hearing or an Administrative Law Judge if not in favor of the member.

Member Appeal Time Frames

Appeals must be initiated within:

- 10 calendar 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.
- 30 calendar days from a resolution notice to request a next level appeal.

Appeals must be resolved within:

- 15 calendar days for standard appeals with First Choice VIP Care Plus.
- Independent Review Entity (IRE) appeals follow existing Medicare appeal time frames.
- 90 calendar days for State Fair Hearings.
- 72 hours for all expedited appeals.

Member Grievances

Members also have the right to file grievances with First Choice 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

First Choice 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 typically education of the provider's office or internal staff occurs.

Claims

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

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.
- Enrolling in Electronic Funds Transfer (EFT) has many advantages:
  - 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 Services through Change Healthcare

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

For electronic claims submission, 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.**
- **First Choice VIP Care Plus Payer ID is 77009.**

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

Please note, in order to complete the enrollment form, you will need your First Choice VIP Care Plus provider number, which can be found on the paper remit. 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 First Choice VIP Care Plus Provider Services at 1-888-978-0862.

Claims - How to Submit Paper Claims

Providers may submit new and corrected paper claims to:

First Choice VIP Care Plus
Claims
P.O. Box 7106
London, KY 40742-7106

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 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%)

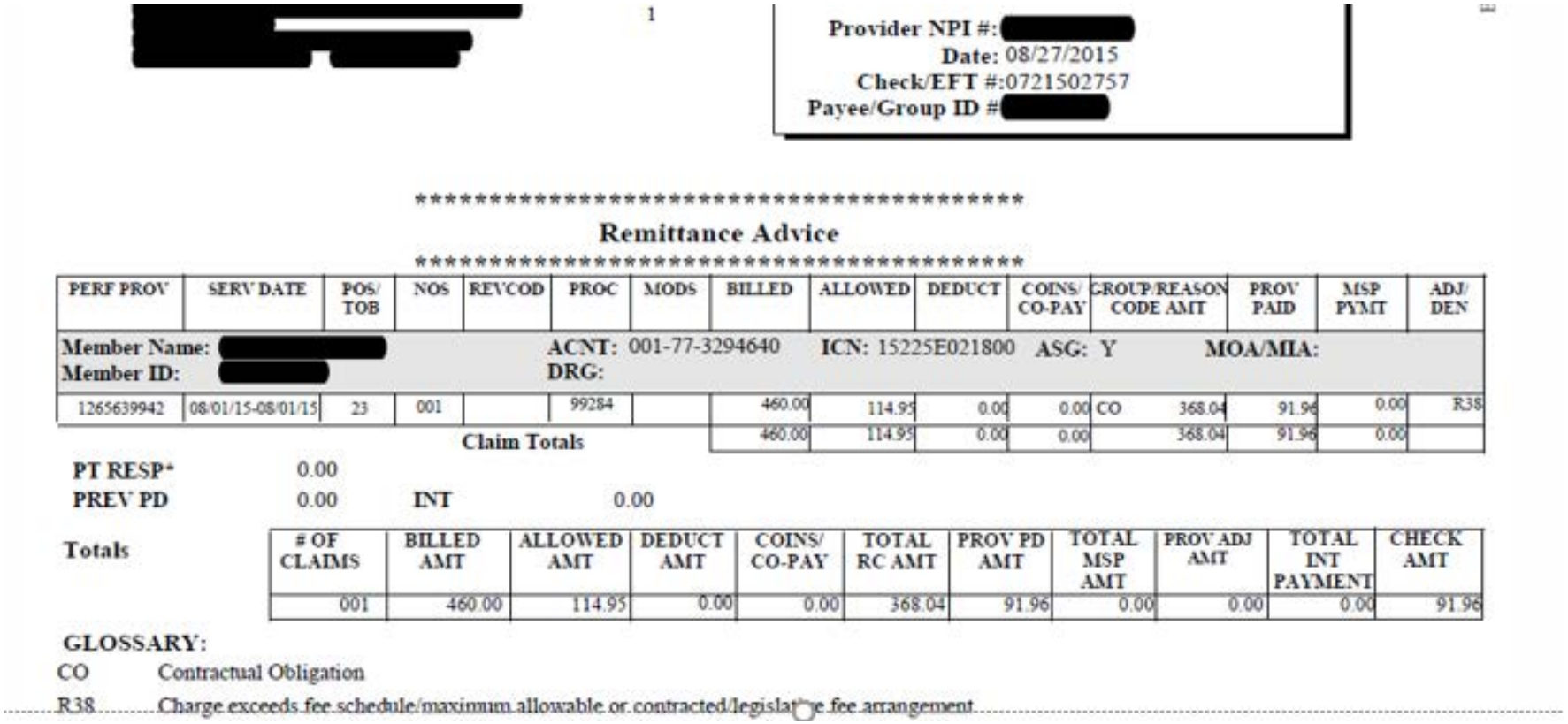
Medicaid Allowable $95.00

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

Insurance Payable Amount: $95.00

*example only

Sample Remittance Advice



[redacted]

1

Provider NPI #: [redacted]
Date: 08/27/2015
Check/EFT #:0721502757
Payee/Group ID #[redacted]

****

Remittance Advice

****

PERF PROV	SERV DATE	POS/ TOB	NOS	REVCOD	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS/ CO-PAY	GROUP/REASON CODE AMT	PROV PAID	MSP PYMT	ADJ/ DEN
Member Name: [redacted] **ACNT:** 001-77-3294640 **ICN:** 15225E021800 **ASG:** Y **MOA/MIA:**														
Member ID: [redacted] **DRG:**														
1265639942	08/01/15-08/01/15	23	001		99284		460.00	114.95	0.00	0.00	CO 368.04	91.96	0.00	R38
						Claim Totals	460.00	114.95	0.00	0.00	368.04	91.96	0.00	

PT RESP* 0.00
PREV PD 0.00 **INT** 0.00

Totals

# OF CLAIMS	BILLED AMT	ALLOWED AMT	DEDUCT AMT	COINS/ CO-PAY	TOTAL RC AMT	PROV PD AMT	TOTAL MSP AMT	PROV ADJ AMT	TOTAL INT PAYMENT	CHECK AMT
001	460.00	114.95	0.00	0.00	368.04	91.96	0.00	0.00	0.00	91.96

GLOSSARY:

CO Contractual Obligation

R38 Charge exceeds fee schedule/maximum allowable or contracted/legislative fee arrangement

Claims – Provider Claim Inquiry / Dispute

Real time claim status is available via NaviNet or by calling Provider Services at 1-888-978-0862.

- First Choice VIP Care Plus processes electronic claims on average in fourteen (14) calendar days and paper claims in thirty (30) calendar days.
- If a First Choice 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 a dispute form. This form is located on the First Choice VIP Care Plus website under the Provider Resources tab.
    - 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 their manuals, memos, or other related documents for guidance.

Claims – Provider Claim Inquiry Form

FirstChoice VIP CARE PLUS by Select Health of South Carolina

Provider Claim Dispute Form

A dispute is a request from a health care provider to change a decision made by First Choice 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 an in-network provider	❑ I am an out-of-network provider

Member information	
Name (last, first):_____	Member date of birth:_____
Member ID:_____	

Claim information	
Claim number:_____	Billed amount: $_____
Dates of services: _____	

Prohibition on Improperly Billing Members

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

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 First Choice VIP Care Plus Healthy Connections Prime 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 First Choice 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 Healthy Connections Prime 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 First Choice 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 First Choice VIP Care Plus member for **non-covered** services).

What Can Members be Billed?

First Choice VIP Care Plus Members can be billed for:

- Medicaid participation in cost of care amounts for long-term services and supports, as determined by SCDHHS.
- Medicaid copay for Medicaid only covered DME items.

How the Plan Resolves Balance Billing Problems with Providers

- First Choice VIP Care Plus informs the provider that the member has been improperly billed and educates the provider on balance billing.
- If First Choice VIP Care Plus reimbursed the member for an improperly billed amount, the plan will notify the provider and request reimbursement be made to the plan.
- If, after outreach and education efforts to the provider, First Choice VIP Care Plus identifies ongoing improperly billing activities, First Choice VIP Care Plus may take disciplinary action up to and including termination of the Provider Agreement.

Quality Metrics

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

Care for Older Adults - HEDIS

Care for Older Adults (COA) includes a group of assessments intended to serve as additional preventive screenings for adults age 66 and over. First Choice 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

First Choice 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 records in order to satisfy the HEDIS requirement.

Care for Older Adults - HEDIS

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.

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

Influenza Vaccine – Consumer Assessment of Healthcare Provider and Systems Survey (CAHPS)

We ask for your help, as a provider, in helping to ensure your patients receive influenza vaccines. 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 - CAHPS

Please be reminded that 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 Sanofi Pasteur Seqirus Inc	**Fluarix Quadrivalent (2020/2021) (Pres Free) & Flulaval Quadrivalent (2020/2021) (Pres Free) Fluzone Quadrivalent (2020/2021) (Pres Free)** **Afluria Quadrivalent (2020/2021) (Pres Free)**
90688	Sanofi Pasteur Seqirus Inc	**Fluzone Quadrivalent (2020/2021)** **Afluria Quadrivalent (2020/2021)**
90756	**Seqirus Inc**	**Flucelvax Quadrivalent (2020/2021)**

Controlling Blood Pressure - HEDIS

Our plan is assessed on how well our providers are controlling their patients' (our members') blood pressure through the HEDIS measure, Controlling High Blood Pressure. This measure determines the percentage of patients 60 to 85 years of age who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled during the measurement year, based on the following criteria:

- Patients 60 to 85 years of age with a diagnosis of diabetes whose BP was less than 140/90 mm Hg.
- Patients 60 to 85 years of age without a diagnosis of diabetes whose BP was less than 150/90 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.

Controlling Blood Pressure - HEDIS

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 - HEDIS

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

Adult BMI - HEDIS

Providers treating our members may report completed Adult BMI Assessments (ABA) using ICD-10-CM codes. This is an important indicator which can be used to screen for weight categories that may lead to health problems.

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

Adult BMI HEDIS Guidelines

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

Medication Reconciliation Post Discharge - HEDIS

CMS understands the importance of providing Transitional Care Management (TCM) with Medication Reconciliation Post-discharge (MRP) in order to provide quality care for your patients. Therefore, CMS adopted the MRP HEDIS measure and has also designated it as a Star measure. Medication reconciliation 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 - HEDIS

If coding guidelines are met, MRP is reimbursed through two Transitional Care Management service codes 99495 and 99496; otherwise, it can be reported with a non-reimbursable CPT Category II code 1111F. T he 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.

Urinary Incontinence – Health Outcomes Survey (HOS)

One way CMS monitors the quality of care of beneficiaries enrolled in Medicare Advantage plans is through the Health Outcomes Survey (HOS). One area of inquiry on the HOS survey is urinary incontinence (UI), which can be associated with decreased quality of life. UI affects up to 30% of elderly people; and 85% of long-term care facility residents will suffer with UI. However, the true incidence of this disorder may be underestimated due to the social stigma of UI or the assumption that UI is a normal part of aging.

On the HOS survey beneficiaries are asked the following questions about UI:

1. Many people experience leakage of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine?
2. During the past six months, how much did leaking of urine make you change your daily activities or interfere with your sleep?
3. ***Have you ever talked with a doctor, nurse, or other health care provider about leaking of urine?***
4. ***There are many ways to control or manage the leaking of urine, including bladder training exercises, medication, and surgery. Have you ever talked with a doctor, nurse, or other health care provider about any of these approaches?***

Urinary Incontinence - HOS

As you can see, questions **3** and **4** ask about conversations beneficiaries have had with their doctors. Because UI is often a sensitive and embarrassing topic for many patients, they may not initiate the discussion if they are experiencing issues with UI.

Therefore, we are looking to our providers to start these conversations with our members, which in turn may help them feel more comfortable discussing these issues. **Simply ask them, "Have you ever leaked urine?"** This simple question may be all it takes to reduce their risk of getting UTIs, suffering from depression, or being institutionalized, and may just result in their having an overall better quality of life.

Other Quality Measures

- ✓ Breast Cancer Screening
- ✓ Colorectal Cancer Screening
- ✓ Diabetes -
  - ➢ Medication Adherence; Eye Exam; Kidney Disease Monitoring; HbA1c Control
- ✓ Plan All-Cause Readmission
- ✓ Follow-up after Hospitalization for Mental Illness
- ✓ Improving or Maintaining Physical and Mental Health
- ✓ Osteoporosis Management in Women Who Had a Fracture (OMW)
- ✓ Rheumatoid Arthritis Management (ART)

Additional Information/Resources

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

Medicare Advantage Risk Adjustment

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?

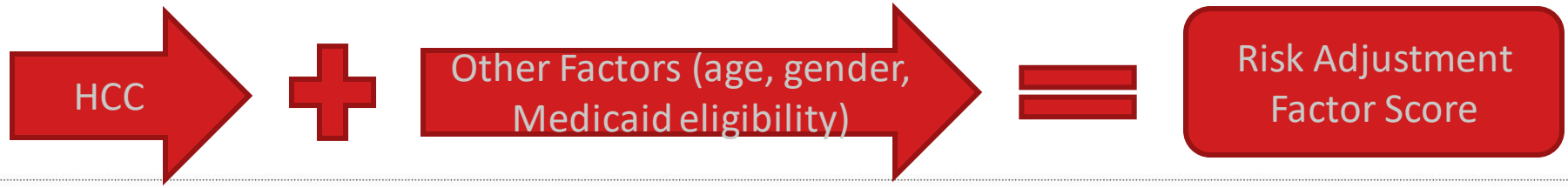
- To accurately reflect the health of each MA plan's membership.
- To ensure MA plans have adequate resources to reimburse providers treating MA beneficiaries.
- So MA plans can rely on predictable and actuarially sound payments from CMS in order to provide enough resources to treat and manage all beneficiaries.

What methodology is used for risk adjustment?

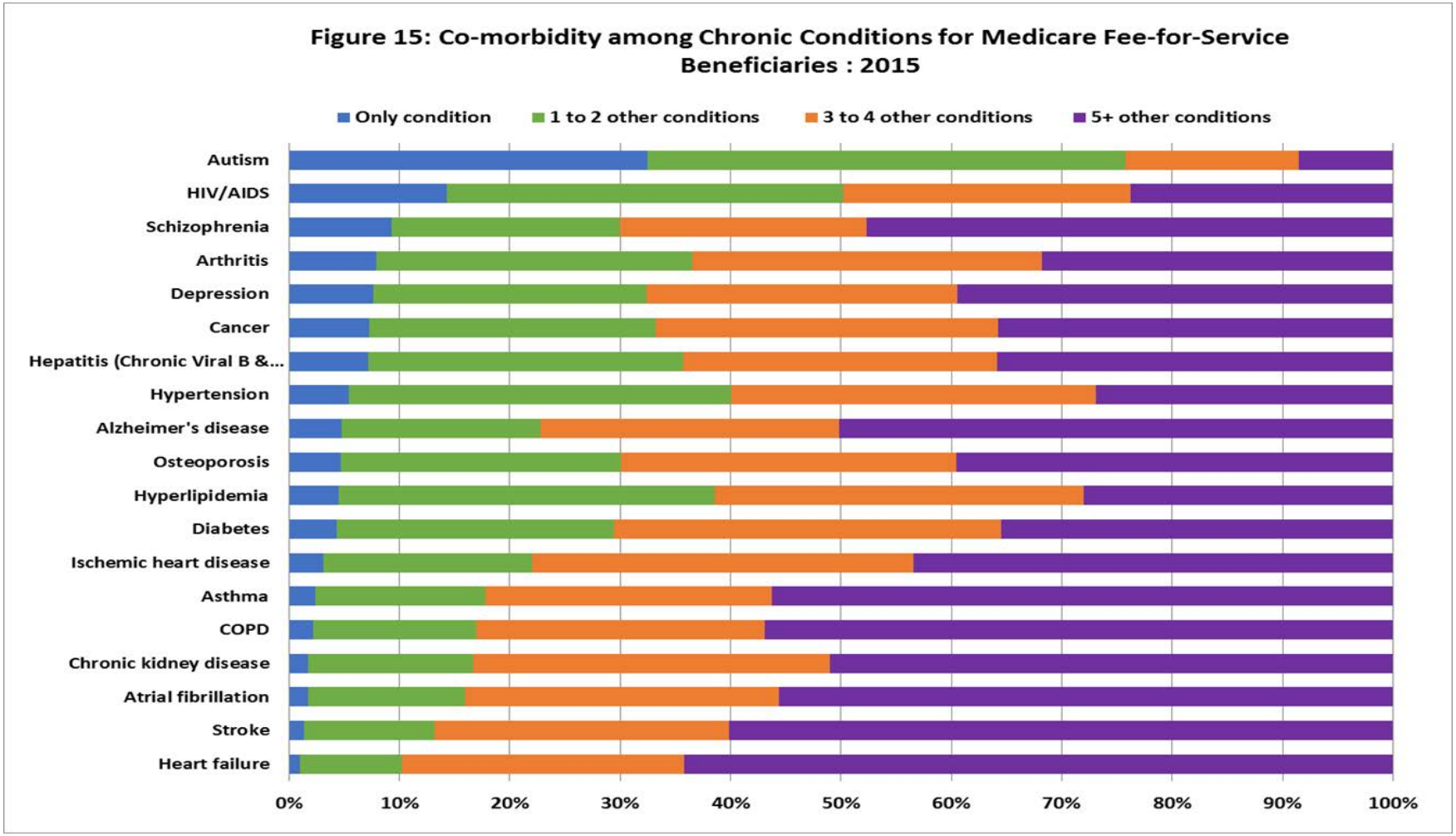
- CMS uses a disease model to determine a risk "score" for each member. The model takes individual diagnosis codes and combines them into broader diagnosis groups, which are then refined into **Hierarchical Condition Categories (HCCs)**. HCCs, together with demographic factors such as age and gender, 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 the reimbursements you deserve, 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. First Choice VIP Care Plus would like to work with providers to find safer alternatives for our members over age 65. Please contact the member's care coordinator at **1-888-978-0862**, option 5, and we will be glad to assist you.

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

Beers Criteria Printable Pocketcard - American Geriatrics Society

Advance Directives

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

Advance Directive — Member Rights

Member rights under federal law:

- To decide what medical care they want to receive, if in the future they are unable to make their wishes known.
- To choose an individual to act on their behalf to make health care decisions in the event they are unable to make these decisions on their own.

Advance Directives — Provider Responsibilities

Provider's responsibilities:

- Discuss and offer to assist with facilitation of advance directives for individuals.*
- Maintain written policies and procedures concerning advance directives with respect to all adults receiving care.

* Must be in compliance with 42 C.F.R. 489.100.

Advance Directives — Provider Responsibilities (cont.)

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

Advance Directives — Provider Responsibilities (cont.)

- **Personal care services** — In advance of the individual coming under the care of the personal care services provider or at the time of the first home visit, as long as the information is furnished before care is provided.
- **Hospice program** — At the time of initial receipt of hospice care by the individual from the program.

Report suspected fraud, waste or abuse to First Choice VIP Care Plus

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

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

First Choice VIP Care Plus Special Investigative Unit
200 Stevens Drive
Philadelphia, PA 19113

Reports may also be sent directly to the U.S. Department of Health and Human Services one of the following ways:

By calling 1-877-7SAFERX (772-3379)
Online at hhstips@oig.hhs.gov

Information may be left anonymously.

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

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

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

14% of adult 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

The Disability Experience

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 First Choice VIP Care PLUS Member Rights

First Choice VIP Care Plus Members all need and expect:

-Right care

-Right place

-Right time

The First Choice VIP Care PLUS Member's Access to Healthcare

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.

First Choice 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 that 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 because you can’t walk.”

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

Communication

Two aspects of communication:

- Engagement and listening
- Using the right auxiliary aids and services to accommodate for limitations of:
    - 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

Use teach back techniques to ensure the member understands 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:

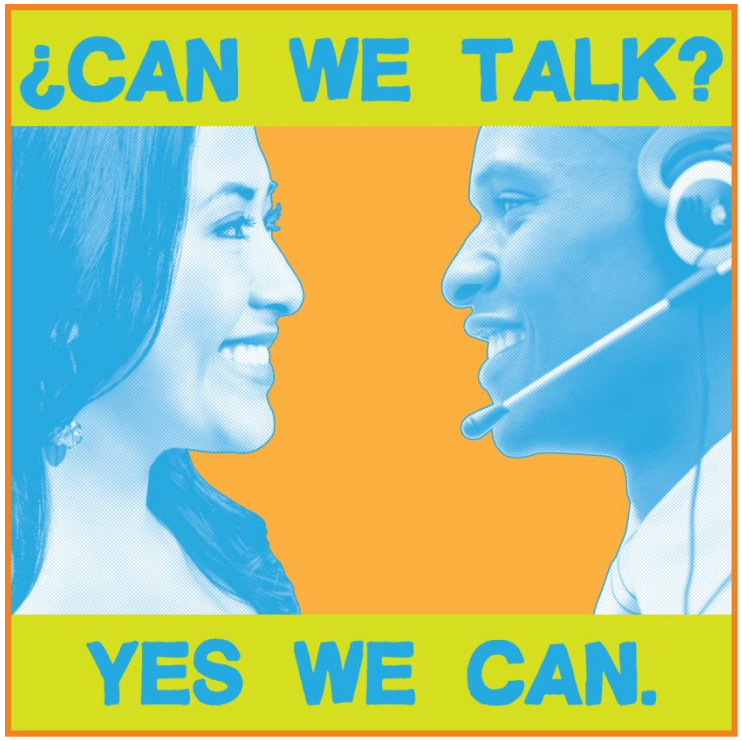
Organized into 4 categories:

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

First Choice VIP Care PLUS CLAS Program

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

Interpretation Services



Free language services for First Choice members anywhere, anytime.

Call Provider/Member Services 1-888-978-0862 OR

the 24 Hour Nurse Help Line 1-855-843-1147 to be connected.

Office Location Accessibility

Office Location Accessibility

- Provider offices must be aware 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

Attention needs to be given to 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 hi/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?

Behavioral Health Crisis Treatment

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 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 usually is less thorough than on the exam table, and does not provide the member equal medical services.

Common Questions and Answers

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, what is 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. Both 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!

FirstChoice VIP CARE PLUS
by Select Health of South Carolina

Healthy Connections PRIME