The Advantage

A Newsletter for Providers

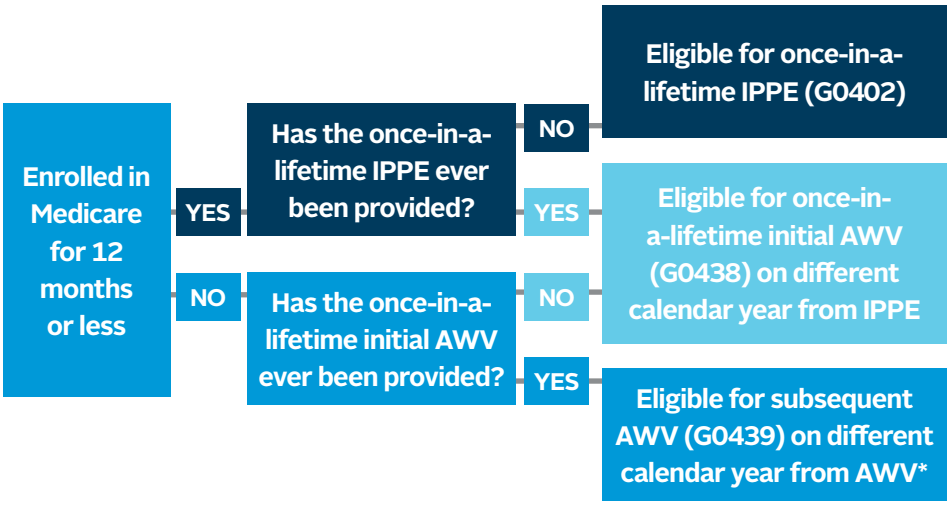
Medicare Annual Wellness Visit

How do Annual Wellness Visits benefit patients and providers?

The **Annual Wellness Visit (AWV)** is not your typical physical exam; it is an opportunity for the primary care provider and health care team to perform screenings and immunizations, manage chronic conditions, and provide education and counseling about preventive services on an annual basis. The visit allows the health care team to talk about issues that are not part of a problem-focused visit and learn about social determinants of health that may be affecting your patient's well-being.

When your patients are newly enrolled in Medicare, they are eligible for their once per lifetime wellness visit known as the **Initial Preventive Physical Examination (IPPE)**. Members are eligible for the IPPE during the first 12 months of enrollment in Medicare. After 12 months, members may receive their initial **Annual Wellness Visit (AWV)**. Once the initial AWV has been performed, your patient is eligible for subsequent AWVs once per calendar year, as seen in the table below. Please note that each of these exams — the IPPE, the first AWV, and subsequent AWVs — each has its own CPT code.

While there is no copay for the AWV, there may be a copay for additional services conducted, such as addressing other medical problems or performing diagnostic imaging, during the visit that are not covered under the preventive benefits. These additional services can also be submitted on the AWV claim. Providers are also eligible for an additional $175 for submitting a completed Subjective, Objective, Assessment, Plan (SOAP) note through ePASS® — see below for more information. To remove barriers to completion during the COVID-19 public health emergency, several preventive services and certain wellness visits, including the AWV, can be furnished via telehealth with the member at home.



Summer 2021

Table of contents

www.keystonefirstvipchoice.com

Keystone First VIP Choice®

Code	IPPE "Welcome to Medicare"	AWV
Visit location	✓ In office	✓ In office ✓ Telehealth
Frequency	✓ Once per lifetime	✓ Once per calendar year
CPT code	✓ G0402	✓ G0438 (initial) ✓ G0439 (subsequent)
Cost share	✓ $0	✓ $0
Health Risk Assessment		✓ Required by CMS
Review/update	✓ Medical history ✓ Medication reconciliation ✓ Social history	✓ Medical history ✓ Medication reconciliation ✓ Family history
	Potential risk factors for: ✓ Depression ✓ Mood disorders	Potential risk factors for: ✓ Depression ✓ Mood disorders
	✓ Functional assessment and safety level	✓ Functional assessment and safety level
Exam or measure	✓ Height, weight, BMI, and blood pressure ✓ Visual acuity screen ✓ Other factors deemed appropriate based on the patient's medical and social history and current clinical standards	✓ Height, weight, BMI, and blood pressure ✓ Visual acuity screen ✓ Other factors deemed appropriate based on the patient's medical and social history and current clinical standards
		✓ Detect any cognitive impairment the patient may have
		✓ Establish a list of current providers and suppliers
Planning	✓ End-of-life planning, on patient agreement	✓ Give advance care planning services at the patient's discretion
	✓ Educate, counsel, and refer based on the previous components	
	✓ Educate, counsel, and refer for other preventive services	
		✓ Establish an appropriate written screening schedule for the patient, such as a checklist for the next five to 10 years.
		✓ Establish a list of patient risk factors and conditions where primary, secondary, or tertiary interventions are recommended or underway.
		✓ Give the patient personalized health advice and appropriate referrals to health education or preventive counseling services or programs.

Source: "Medicare Wellness Visits," MLN Educational Tool, February 2021, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html.

ePASS® SOAP note incentive

Our plan has collaborated with Inovalon® to provide clinical documentation services over a secure online portal called ePASS. We are incentivizing primary care providers (PCPs) who submit a completed SOAP note through ePASS after face-to-face or telehealth encounters with our members. ePASS will also assist PCPs with care coordination, risk adjustment, and quality of care gaps.

Earning an incentive through the ePASS program

PCPs can earn an incentive by completing an assessment for our members. Below you will find information to help you understand the requirements for completing a SOAP note, as well as the requirements which must be met to earn an ePASS incentive.

General information

- The eligible dates of service for this program are January 1, 2021, through December 31, 2021. Submissions must be received by December 31, 2021.
- Our members must be enrolled at the time of the encounter for the PCPs to be considered eligible for an incentive payment.
- All SOAP notes must be submitted electronically using ePASS.
- If you have not previously registered for ePASS, you can obtain a provider toolkit and a registration code from Inovalon by calling **1-877-448-8125**.

Incentive opportunity

- **The potential earning per tax ID number per unique member in 2021 is $175.**
- Earn $175 when you submit an initial electronic SOAP note within 120 days of having a face-to-face or telehealth encounter with any of our members between January 1, 2021, and December 31, 2021.

Inovalon, on behalf of our plan, will administer the incentive payments for completed assessments. Payment will be processed monthly for assessments completed in the previous calendar month.

To receive the incentive payment, Internal Revenue Service (IRS) guidelines require that we collect a W-9 from you. To easily manage this process, this information will be collected in a secure, web-based portal. To assist you with the incentive payment setup process, we have enclosed a Quick Start Guide with step-by-step instructions for completing the required steps in the secure online portal. We will also send details regarding this process to the email address you submitted when registering for your ePASS account.

If W-9 paperwork is not submitted through the online portal, incentive payments will not be processed.

Incentive payments are processed monthly for SOAP notes submitted in the prior month. Once registration is completed, you can expect to receive the incentive payment within three to five weeks of submitting the SOAP note in ePASS.

If you have questions about the registration process or have payment inquiries, please contact Inovalon Incentive Support toll free at **1-844-823-9408**, Monday through Friday, 8 a.m. to 5 p.m. ET (excluding holidays).

For questions or assistance regarding ePASS, please call **1-877-448-8125** to speak with an Inovalon associate. You may also send ePASS-related questions to Keystone First VIP Choice at **kfvipc.pa@amerihealthcaritas.com.**

What is the Health Outcomes Survey?

The **Health Outcomes Survey (HOS)** assesses the ability of a Medicare Advantage (MA) organization to maintain or improve the physical and mental health of its members over time. A random sample of health plan members is selected from eligible MA plans to participate in the HOS program each year. Two years later, the baseline respondents are surveyed again, so those surveyed in 2021 will be surveyed again in 2023. Surveys are first distributed by mail from late July through November and concluded with telephone-assisted surveys for participants who have not responded.

The survey focuses on maintaining or improving the overall health of our members. Many of the questions relate to how the member feels physically and emotionally and how those feelings impact their daily activities. Physical health is inextricably linked to mental health, and physical illness may cause psychiatric symptoms. At the very least, physical illness is likely to exacerbate psychiatric symptoms, such as anxiety and depression, in patients with mental health problems. Therefore, assessment and management of physical health in this population are essential[1]. When assessing patients, please assess their mental health status and how this may be impacting their activity levels.

Several of the questions on the survey directly ask about conversations beneficiaries have had with their doctors — for example, conversations related to urinary incontinence and physical activity.

Urinary incontinence (UI) — 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[2]. However, the true incidence of this disorder may be underestimated due to the social stigma of UI or the assumption that UI is a normal part of aging. On the HOS survey, beneficiaries are asked the following questions about UI:

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

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

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

Physical activity — Another area of focus of the HOS survey is physical activity. Physical activity has been shown to improve quality of life regardless of age, chronic disease, or disability. It can prevent many of the health problems that seem to come with age, such as heart disease, stroke, type 2 diabetes, depression, and some cancers. It also helps muscles grow stronger to allow individuals to keep doing day-to-day activities without becoming dependent on others.[3] On the HOS survey, beneficiaries are asked the following questions about physical activity:

1. **In the past 12 months, did you talk with a doctor or other health provider about your level of exercise or physical activity?**
2. **In the past 12 months, did a doctor or other health provider advise you to start, increase, or maintain your level of exercise or physical activity?**

As you can see, the questions ask about conversations beneficiaries have had with their providers regarding physical activity, **with one specifically asking if they have received any advice from their providers.** You can help your patients answer yes to these question by doing the following:[4]

- **Assess** — Inquire about their level of exercise or physical activity and determine what level of physical activity is safe and appropriate.

- **Advise** — Recommend they should aim to do at least 150 minutes of moderate-intensity physical activity a week, based on their ability. Chair-based exercises may be advisable for frail older people, for example.
- **Agree** — Initiate the decision-making process and reinforce the value of starting, increasing, or maintaining physical activity by setting reasonable expectations and goals.
- **Assist** — Provide the patient with a written prescription, printed support materials, self-monitoring tools (pedometer, calendar), or internet resources.
- **Arrange** — Schedule a follow-up visit, provide telephone or email reminders, or refer the patient for additional assistance.

We recommend you be very specific by providing patients an exercise recommendation, directing them to find something they will find fun, and following up with their progress at every visit. Remember to include exercise counseling on your claim if you do counseling on physical activity during a patient visit.

More details about HOS measures can be found at www.hosonline.org.

Sources:

[1]David P.J. Osborn, "The Poor Physical Health of People with Mental Illness," West J Med, Vol. 175, No. 5, 2001, pp. 329 – 332, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1071612/.

[2]George A. Demaagd, Timothy C. Davenport, "Management of Urinary Incontinence" P & T: A Peer-reviewed Journal for Formulary Management, Vol. 37, No. 6, pp. 345 – 361H, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3411204/.

[3]"Physical Activity," Centers for Disease Control and Prevention, September 28, 2017, https://www.cdc.gov/physicalactivity/index.html.

[4]Rebecca A. Meriwether, et al, "Physical Activity Counseling," Am Fam Physician, 15:77(8), 2008, pp. 1129 – 1136, https://www.aafp.org/afp/2008/0415/p1129.html.

Medicare star rating medication adherence measures

Star ratings were created by the Centers for Medicare & Medicaid Services (CMS) to provide quality and performance information to help Medicare beneficiaries choose a plan. Star ratings range from 1 to 5 (lowest to highest) and reflect the experiences of members regarding the health and drug services they've received. They apply to both Medicare Part C (medical plan) and Part D (pharmacy plan).

Why medication adherence matters as related to star ratings[1]:

- Medication adherence is 33% of the total score for Part D star ratings and is measured for adherence to diabetic medications (excluding insulin), angiotensin-converting enzyme (ACE) inhibitors and angiotensin receptor blockers (ARBs), and statin medications.
- Poor patient adherence to medications for chronic conditions often leads to worse clinical outcomes, more readmissions, and a lower quality of life.
- Patient satisfaction relating to the physician-patient relationship also directly influences and improves medication adherence.

The star rating medication adherence measures are comprised of the following:

1. **Diabetes Medication** — Percentage of plan members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication during the measurement year.
2. **Hypertension (RAS antagonists)** — Percentage of plan members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication during the measurement year.
3. **Cholesterol (Statins)** — Percentage of plan members with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication during the measurement year.
4. **Statin Use in Persons with Diabetes (SUPD)** — Percentage of plan members who have a prescription for at least two diabetes medication fills and who received a statin medication fill during the measurement year.

Medication adherence spotlight

Did you know? Cholesterol-lowering medications

Lifesaving

- Decreased risk of heart attack (54%) and stroke (48%) in thousands of people every year.
- Risk of a second cardiovascular event reduced by almost 50%.

Safe

- Only one person in 10,000 or more develop severe pain and muscle damage.
- Risk for liver damage or diabetes is rare.

Cholesterol medications on VIP formulary — all Tier 1 except for Repatha® PCSK9

Statins	Cholesterol absorption inhibitors	Fibrates	Bile acid sequestrants	Nicotinic acid agents	PCSK9 inhibitors (requires prior authorization from cardiology/ lipid specialist)
Atorvastatin 10, 20, 40, 80 mg	Ezetimibe 10 mg	Fenofibrate tablets 54,160 mg	Cholestyramine powder or packet 4 grams	Niacin tablets ER 500, 750, 1,000 mg	Repatha sub-cu pen 140 mg/ml
Pravastatin 10, 20, 40, 80 mg	Ezetimibe simvastatin 10 – 10, 10 – 20, 10 – 40, 10 – 80 mg	Gemfibrozil 600 mg	Colestipol tablet or packet 1 or 5 grams		Repatha syringe 140 mg/ml
Rosuvastatin 5, 10, 20, 40 mg		Fenofibrate micronized capsules 48, 145, 160 mg	Omega-3 1 gram		
Simvastatin 5, 10, 20, 40, 80 mg					
Lovastatin 10, 20, 40 mg					

Who should be on cholesterol-lowering medications?

- People with atherosclerotic cardiovascular (ASCVD) disease.
- People with a history of:
  - Angina.
  - Cerebrovascular accident (CVA).
  - Myocardial infarction (MI).
  - Peripheral vascular disease (PVD).
- People with high elevations (> 190) of LDL cholesterol.
- People ages 40 – 75 with diabetes.
- People ages 40 – 75 with 10-year risk for an ASCVD event > 7.5% (use ASCVD estimator app).

Is your patient "statin-intolerant"?

- Thirty percent of patients complain of muscle aches, pain, stiffness, or weakness.
- Seventy percent of "statin-intolerant" patients can take statins; it may take patience and persistence.
- Increased risk of diabetes is rare; rhabdomyolysis is even rarer.

Steps for addressing statin intolerance

- Do full assessment of muscle symptoms, such as physical activity, hypothyroidism, vitamin D deficiency, steroid myopathy, and arthritis.
- Check renal and hepatic function, creatine kinase, and urine for myoglobin if you suspect rhabdomyolysis.
- Review medications; avoid fibrates and macrolides, and discuss steroids and bisphosphonates.
- Consider a statin "holiday" of two to four weeks; if symptoms persist, you can rule out statin intolerance.
- Consider restarting a lower dosage or a different statin.
- Consider a statin that has fewer side effects, such as rosuvastatin, pravastatin, or fluvastatin.
- Consider trying alternate day or twice-weekly statin.

[1]"Medicare Medication Adherence and Star Ratings Importance," Louisiana Healthcare Connections, May 27, 2020, https://www.louisianahealthconnect.com/newsroom/medicare--medication-adherence-and-stars-ratings-.html.

Care for Older Adults measures

Care for Older Adults (COA) includes a group of assessments intended to serve as additional preventive screenings for adults age 66 and older. Our plan tracks these services as part of our ongoing Healthcare Effectiveness Data and Information Set (HEDIS®) Quality Improvement Program:

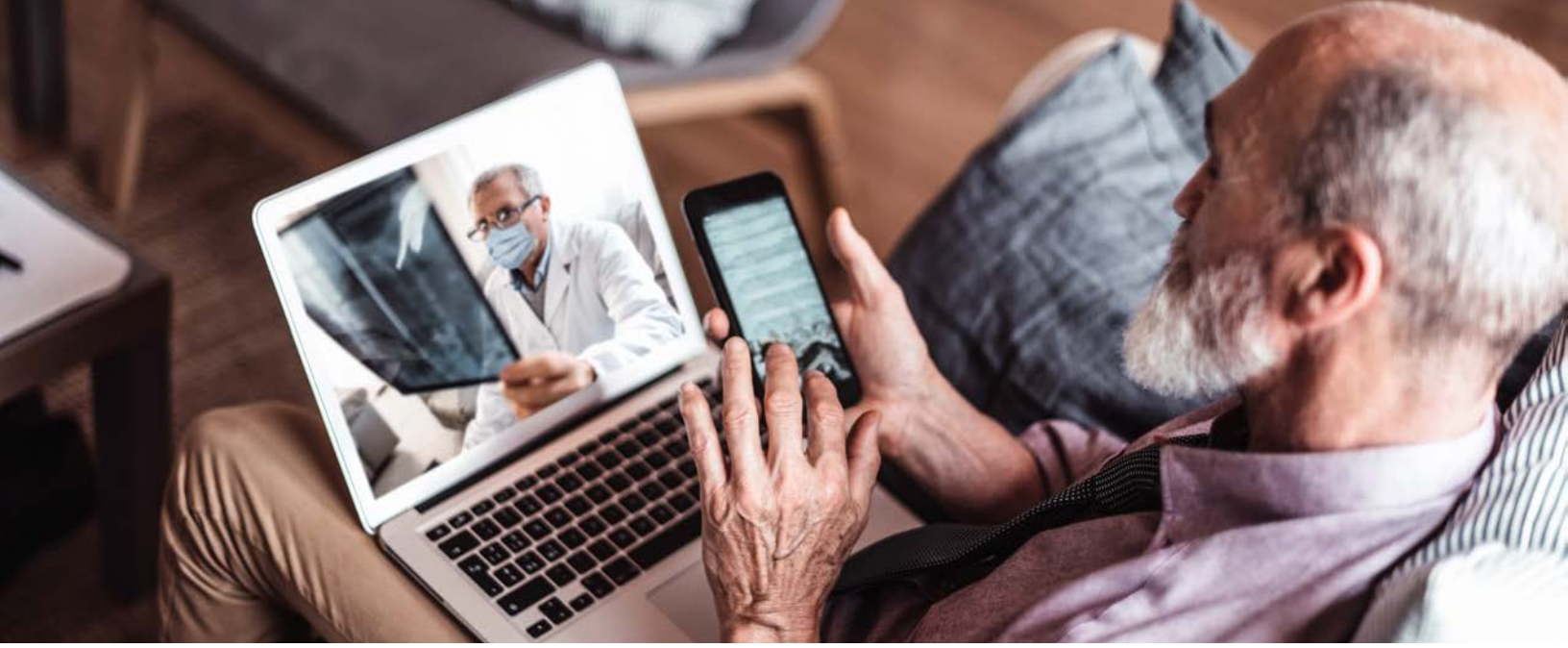
- ✓ Advance care planning.
- ✓ Pain assessment.
- ✓ Functional assessment.
- ✓ Medication review/list.

Our plan can 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 to satisfy the HEDIS requirement.

Providers may also satisfy the COA requirement by completing the assessments and submitting a claim with the appropriate codes. Submitting appropriate codes (CPT/CPT Category II/HCPCS/ICD-10-CM) after the assessments are completed helps inform us that you have completed the assessments and may decrease the need for us to request medical records to review for this information.

Code	Type	Measure	Description
99483	CPT	Advance Care Directive	Cognitive impairment assessment and care planning.
99497	CPT	Advance 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 care professional; first 30 minutes, face-to-face with patients, family member(s), and/or surrogate.
1123F	CPT II	Advance Care Directive	Advance care planning discussed and documented. Advance care plan or surrogate decision-maker documented in the medical record.
1124F	CPT II	Advance 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.
1157F	CPT II	Advance Care Directive	Advance care plan or similar legal document present in the medical record.
1158F	CPT II	Advance Care Directive	Advance care planning discussion documented in the medical record.
S0257	HCPCS	Advance Care Directive	Counseling and discussion regarding advance directives or end-of-life care planning and decisions, with patient and/or surrogate.
Z66	ICD-10-CM	Advance Care Directive	Do not resuscitate.
90863	CPT	Medication Review	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services.
99483	CPT	Medication Review	Cognitive impairment assessment and care planning.
99605	CPT	Medication Review	Medication therapy management services.
99606	CPT	Medication Review	Medication therapy management services.
1160F	CPT II	Medication Review	Review of all medications by a prescribing practitioner or clinical pharmacist and documented in the medical record.
99483	CPT	Functional Status Assessment	Cognitive impairment assessment and care planning.
1170F	CPT II	Functional Status Assessment	Functional status assessed.
G0438	HCPCS	Functional Status Assessment	Annual wellness visit, includes a personalized prevention plan of service (PPS), initial visit.
G0439	HCPCS	Functional Status Assessment	Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit.
1125F	CPT II	Pain Assessment	Pain severity quantified; pain present.
1126F	CPT II	Pain Assessment	Pain severity quantified; NO pain present.



Telehealth

Why telehealth?

When your patients, our members, get sick or even need a routine checkup, your office is likely the first place they call. But various circumstances may not allow for the most timely in-person care. While telehealth technology and its use are not new, our plan has supported the transition to telehealth services during the COVID-19 pandemic to increase access to PCPs and specialists, including behavioral health providers, to help preserve the patient-provider relationship when in-person visits are not possible.

Beginning in March 2020, Keystone First VIP Choice expanded its coverage of telehealth, in response to new CMS guidance, to include coverage in all areas (not just rural) and in all settings, to allow the use of popular video chat applications, and to increase the allowed services. In accordance with CMS billing guidance (MLN Connects, April 3, 2020), when billing professional claims for all telehealth services with dates of service on or after March 1, 2020, and for the duration of the public health emergency (PHE), providers can bill with:

- Place of service (POS) equal to what it would have been had the service been furnished in person.
- Modifier 95, indicating that the service rendered was actually performed via telehealth.

There are also options for virtual check-ins and e-services.

Another option

Telehealth through MDLIVE is one more option to help your patients receive timely access to care. MDLIVE is an additional benefit to our members which offers them access to immediate online doctor visits 24 hours a day, seven days a week, in the event their regular provider is unavailable. A telehealth visit enables quick access for low-acuity patients who have transportation or mobility barriers to receiving in-person care.

Patients with urgent medical concerns are encouraged to visit urgent care or the ER; but telehealth may help patients receive appropriate care and avoid unnecessary visits to urgent care or the ER.

What about continuity of care?

MDLIVE is committed to helping ensure that patients follow up with their existing PCPs for continuity of care. With patient consent, the PCP will receive access to patient visit information.

Why MDLIVE?

Telehealth visits through MDLIVE offer:

- Privacy and protection via MDLIVE's secure platform.
- Flexibility to use secure video or telephone options.
- E-prescription capabilities.

How can my patients access MDLIVE?

Patients may go to **www.mdlive.com** to get started. Registration takes only a few minutes. MDLIVE also offers patients a no-cost app via the Apple App Store® and Google Play™ store for Android. Note, the app is no-cost, but standard data and messaging fees may apply.

Is MDLIVE looking for providers to deliver telehealth services?

Yes. If you are interested in becoming a telehealth provider through MDLIVE, please visit **www.mdlive.com/provider**.

Let's work together to prevent hospital readmissions through appropriate follow-up care

Defining a hospital readmission

For Medicare, a hospital readmission occurs when a patient is admitted to a hospital within a 30-day time period after being discharged from an earlier (initial) hospitalization. This includes hospital readmissions to any hospital, not just the hospital at which the patient was originally hospitalized. Medicare uses an "all-cause" definition of readmission, meaning that hospital stays within 30 days of a discharge from an initial hospitalization are considered readmissions, regardless of the reason for the readmission.

Penalty highlights for 2021[1]

- CMS has penalized 2,545 out of 3,080 hospitals evaluated (83%).
- CMS will cut payments to the penalized hospitals by as much as 3% for each Medicare case during fiscal year 2021, which runs October 1, 2020, through September 30, 2021.
- Thirty-nine hospitals were hit with the maximum penalty for fiscal year 2021, down from 56 hospitals in fiscal year 2020.
- The average penalty will be a 0.69% payment cut for each Medicare patient.
- Of the 3,080 hospitals evaluated, 613 will receive a penalty of 1% or more.

What can providers do to help minimize readmissions?

For Medicare patients, hospitalizations can be stressful; even more so are subsequent readmissions. Hospitals and physicians can engage in several activities to lower their rate of readmissions:

- Clarifying patient discharge instructions.
- Coordinating with specialty care providers and the patient's PCP for follow-up care.
- Providing transitional care management (TCM) with medication reconciliation post-discharge (MRP) services, as appropriate.
- Utilizing telehealth for follow-up care, as not all follow-up requires an in-person visit.
- Providing essential patient education, as low health literacy is a factor in poor follow-up.

How can we help you to minimize this risk while improving care for our members?

Our Care Management team can support you in the following ways:

- Work with your case management team to coordinate the member's discharge.
- Provide medication reconciliation post-discharge in the member's home.
- Ensure home-based services are in place, such as durable medical equipment, home health, and therapies.
- Help facilitate members following up with the appropriate specialist or PCP by scheduling an appointment prior to discharge with the appropriate provider within seven days.
- Help the member overcome any barriers, which may prevent them from attending follow-up care, such as arranging transportation.
- Update the member's individualized care plan to address barriers to recovery, provide education needed to manage health, and help prevent readmissions.

[1]Ayla Ellison, "CMA fines 2,545 hospitals for high readmissions: 5 things to know," Becker's Hospital CFO Report, November 2, 2020, https://www.beckershospitalreview.com/finance/cms-fines-2-545-hospitals-for-high-readmissions-5-things-to-know.html.

Addressing depression and anxiety during COVID-19 for patients and providers

The pandemic has increased mental health risks caused by job loss and risk of job loss; isolation and social distancing; juggling children and work; not having proper supplies; fear of getting sick; and managing expanded workloads. We even know that 54% of Americans fear they may lose their jobs due to the coronavirus outbreak and another 50% of workers say they are fearful of returning to work due to health concerns. Besides the risks, there are psychological effects of social isolation stemming from social distancing measures, such as acute stress disorder, symptoms of post-traumatic stress disorder, depression, anger and confusion, irritability, insomnia, and suicidal ideation.[1,2,3]

Social connection risk continuum[4]	
High social connection is associated with protection.	Low social connection is associated with risk.

You and your staff are on the front line, and, considering the challenges, it is OK to not be OK.

- Start the conversation
- Talk with someone you trust about how you are feeling.
- Understand that self-help and healthy coping strategies may not be enough.
- A longer delay in seeking the most appropriate treatment and support will lead to a more difficult recovery.
- Consider seeking appropriate professional help.
- Visit **www.howrightnow.org** for tips on how to begin the conversation.

Strategies for employees and you[5]

- Lead by example to reduce stigma; speak candidly about mental health.
- Connect employees to wellness and health programs, trainings, and seminars like those listed above.
- Make mental health self-assessment tools and materials available.
- Create designated office quiet zones and de-stressing areas.
- Require employees to go offline during lunch breaks.
- Upgrade work-from-home setups.

Practice self-care[6]

- Take breaks from news stories and social media.
- Make time for deep breathing, stretching, meditation, or another activity you enjoy.
- Try to eat healthy, well-balanced meals.
- Exercise regularly and get plenty of sleep.
- Avoid excessive alcohol consumption.
- Talk with people you trust about how you are feeling.

How to help members:

Refer a member to behavioral health services, as appropriate.

Other resources for patients

Visit **www.howrightnow.org**, created by the CDC Foundation. This website provides resources that support mental health during the pandemic and offers ideas for ways to cope with COVID-19-related stress. It also features an interactive tool to help users find resources that address their specific concerns and how to start the conversation about how they are feeling. Other resources on the site include fact sheets, articles, webinars, mobile apps, and crisis hotlines from a variety of reputable organizations such as the Centers for Disease Control and Prevention (CDC), the American Red Cross, the U.S. Department of Veterans Affairs, AARP, and the American Psychological Association.

[1]Holt-Lunstad The Potential Public Health Relevance of Social Isolation and Loneliness: Prevalence, Epidemiology, and Risk Factors. The Gerontological Society of America, 2018, pp. 127 – 130.

[2]"COVID-19's Impact on Mental Health and Workplace Well-being," National Institute for Health Care Management Foundation, October 16, 2020. https://www.nihcm.org/categories/ covid-19-s-impact-on-mental-health-and-workplace-well-being.

[3]"The Negative Psychological Effects of Quarantining & How to Mitigate Them," PsychU, May 4, 2020, https://www.psychu.org/the-negative-psychological-effects-of-quarantining-and-how-to-mitigate-them/.

[4] Holt-Lunstad, "Spotlight on the Problem," National Institute for Health Care Management, October 15, 2018. https://nihcm.org/publications/the-health-impact-of-loneliness-emerging-evidence-and-interventions.

[5]"COVID-19's Impact on Mental Health and Workplace Well-being," National Institute for Health Care Management Foundation, October 16, 2020. https://www.nihcm.org/categories/covid-19-s-impact-on-mental-health-and-workplace-well-being.

[6]"Coronavirus Disease 2019 Stress and Coping," Centers for Disease Control and Prevention, April 30, 2020, www.CDC.gov: https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/ managing-stress-anxiety.html.

June 15 — World Elder Abuse Awareness Day

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

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

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

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

Red flags of elder abuse:

Neglect:

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

Financial abuse/exploitation:

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

Psychological/emotional abuse:

- Unexplained or uncharacteristic changes in behavior, such as withdrawal from normal activities or unexplained changes in alertness.
- Caregiver isolates elder (doesn't let anyone into the home or to speak to the elder).
- Caregiver is verbally aggressive or demeaning, controlling, overly concerned about spending money, or uncaring.

Physical/sexual abuse:

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

Source: https://eldermistreatment.usc.edu/weaad-home/about/

Balance billing

Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997, prohibits Medicare providers from balance billing qualified Medicare beneficiaries for Medicare cost-sharing. Under the requirements of the Social Security Act, all payments from our plan to participating plan providers must be accepted as payment in full for services rendered. Members may not be balance billed for medically necessary covered services under any circumstances. All providers are encouraged to use the claims inquiry processes to resolve any outstanding claims payment issues. Providers may reference CMS MLN Matters® number SE1128 for further details.

Model of Care

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

CMS requires providers who care for our beneficiaries to annually participate in and attest to completing our Model of Care training. This required training can be accessed in any of the following ways:

- In person from a training seminar or a Provider Network Management Account Executive.
- By accessing an online interactive Model of Care training or PDF module on our website, **www.keystonefirstvipchoice.com**, under the Provider Training and Education link.
- By reviewing printed or faxed Model of Care materials.

Community HealthChoices (CHC) and how it works with Keystone First VIP Choice

CHC is designed for individuals 21 and older who:

- Receive Medicaid-only coverage and receive or need long-term services and supports (LTSS). These Participants may reside in community-based settings or in private or county nursing facilities.

or

- Receive both Medicare and Medicaid coverage (dual eligible). These Participants can include those with or without LTSS needs.

Those who receive both Medicare and Medicaid are eligible to enroll in a Dual Eligible Special Needs plan (D-SNP) which is a Medicare Advantage plan that primarily or exclusively enrolls individuals who are enrolled in both Medicare and Medicaid. Keystone First VIP Choice is a D-SNP and is available to CHC Participants. This may include community well dual (CWD) participants and participants who are nursing facility ineligible (NFI) or not nursing facility clinically eligible (NFCE) but who have Medicare and Medicaid. Participants may choose a D-SNP that is aligned with the Keystone First CHC plan, unaligned with our CHC plan (another company's D-SNP), or remain in Medicare fee-for-service.

The goal of Keystone First CHC and its companion D-SNP (Keystone First VIP Choice) is to provide a coordinated experience from the perspective of full dual eligible Participants who enroll in both. This includes but is not limited to:

- An integrated assessment and care coordination process that spans all Medicaid and Medicare services.
- Administrative integration to evolve over the life of CHC.
- Keystone First CHC cooperating fully with the Department of Human Services (DHS) and CMS in ongoing efforts to streamline administration of the two programs, which may include, but is not limited to, coordinated readiness reviews, monitoring, enrollment, Participant materials, and appeals processes.

D-SNP coordination with CHC

- Keystone First CHC (CHC plan) will pay Medicare deductibles and coinsurance amounts relating to any Medicare-covered service for dual eligible participants, not to exceed the contracted plan rate. The CHC Plan will not be responsible for copayments or cost-sharing for Medicare Part D prescriptions.
- If no contracted CHC plan rate exists or if the provider of the service is not in the CHC plan provider network, the CHC plan must pay deductibles and coinsurance up to the applicable Medical Assistance (MA) fee schedule rate for the service.
- For Medicare services that are not covered by MA or CHC, the CHC plan must pay cost-sharing to the extent that the payment made under Medicare for the service and the payment made by the CHC plan do not exceed 80% of the Medicare-approved amount.
- The CHC plan and its subcontractors and providers are prohibited from balance billing participants for Medicare deductibles or coinsurance. The CHC plan must provide a dual eligible Participant access to Medicare products and services from the Medicare provider of his or her choice. The CHC plan is responsible to pay any Medicare coinsurance and deductible amount, whether or not the Medicare provider is included in the CHC plan's provider network and whether or not the Medicare provider has complied with the prior authorization requirements of the CHC plan.

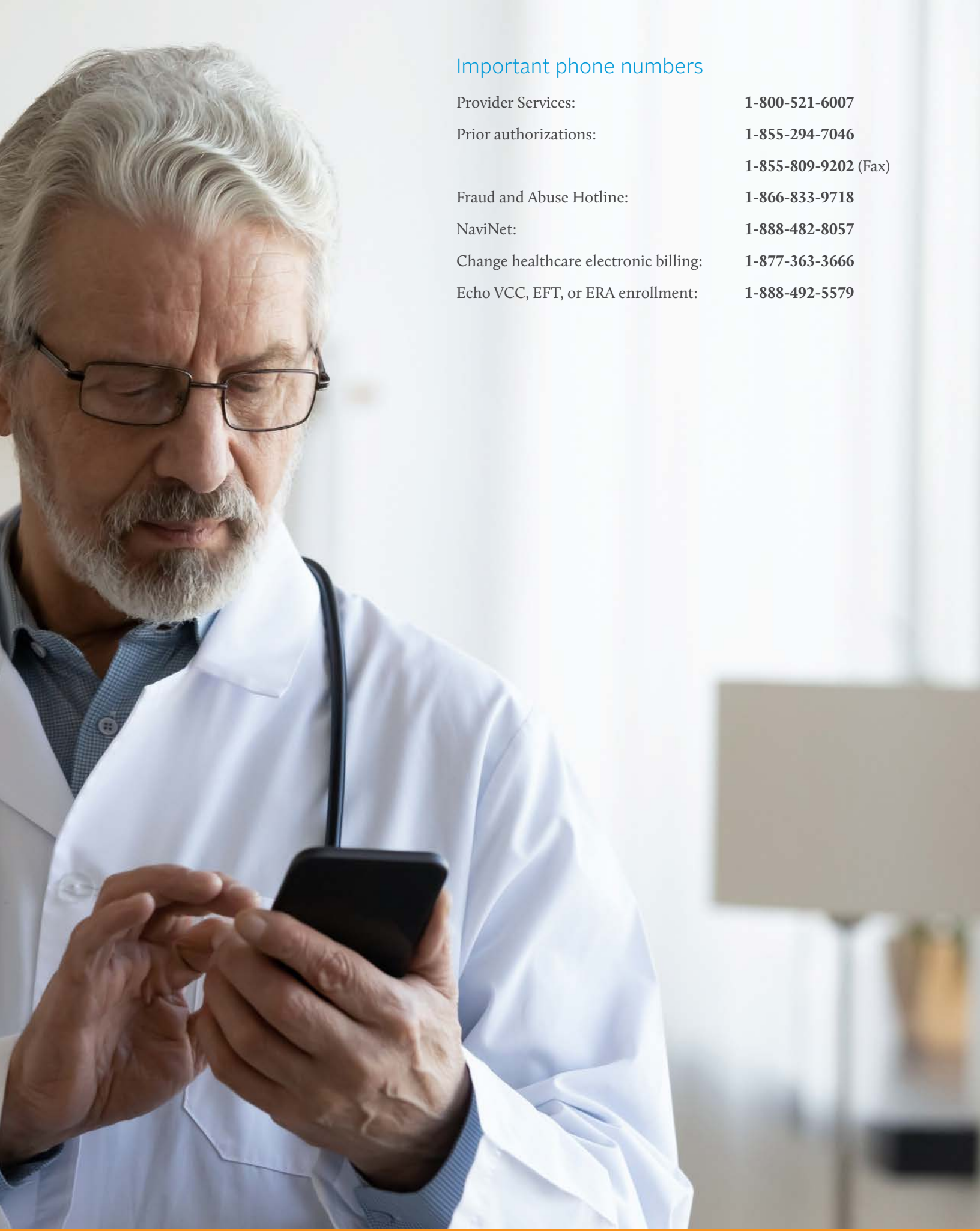
If you would like more information or training on CHC, please reach out to your Account Executive.

Prior authorization lookup tool available on plan website

We are excited to introduce the new prior authorization lookup tool. This new, user-friendly resource allows users to enter a CPT or a HCPCS code to verify authorization requirements in real time before delivery of service.

The prior authorization lookup tool was designed to help reduce the administrative burden of calling Provider Services to determine whether prior authorization is required. The tool is easy to use and offers general information for outpatient services performed by a participating provider. To try the prior authorization lookup tool, visit **https://www.keystonefirstvipchoice.com/provider/resources/prior-authorization-lookup.aspx.**

Prior authorization requests cannot be submitted through the tool and should continue to be requested through your current process. We would like to remind you that you can submit your requests electronically via NaviNet. Through your single login to NaviNet, you can request prior authorization and view authorization history. If you are not already a NaviNet user, visit **https://navinet.secure.force.com** to sign up.



Important phone numbers

Provider Services:	**1-800-521-6007**
Prior authorizations:	**1-855-294-7046**
	1-855-809-9202 (Fax)
Fraud and Abuse Hotline:	**1-866-833-9718**
NaviNet:	**1-888-482-8057**
Change healthcare electronic billing:	**1-877-363-3666**
Echo VCC, EFT, or ERA enrollment:	**1-888-492-5579**

The Advantage

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www.keystonefirstvipchoice.com

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