CENTRAL HEALTH E
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A provider newsletter published by Central Health Plan of California

Central Health Medicare Plan Wins Awards from National Firm

Health Metrix Research Inc. bestowed upon Central Health Medicare Plan the 2008 Senior Choice Gold Award. The 2008 Senior Choice Gold Award recognizes only 35 health plans from a nation wide contender pool of over 200 for excellence in benefit design and value, and Central Health Medicare Plan is the only health plan to receive this award in Los Angeles County.

HealthMetrix Research Inc. has also recognized Central Health Medicare Plan for offering one of the best 2008 Medicare Part D Benefit Designs, which includes $0 premium, $0 deductibles, and extended drug coverage through the coverage gap. Central Health Medicare Plan is one of only 23 health plans of over 400 plans nationwide to receive this designation.

HealthMetrix Research Inc. is an independent national managed care research firm. The awards are based on information provided by the Medicare Options Compare database *(http://www.medicare.gov)* and can be reviewed in their entirety at *www.MedicareNewsWatch.com.*

Enrollment Period

Central Health Medicare Plan is experiencing phenomenal demand for our 2008 Medicare benefit packages during the 2008 enrollment period. Central Health Medicare Plan is available to your Medicare patients residing in Los Angeles County and the urban regions of southwest San Bernardino County. Please contact the Customer Service Department at 1-866-314-2427 for a comprehensive list of our coverage area. Two Medicare benefit packages are available to Medicare beneficiaries:

#001: Central Health Medicare Plan is available for all Medicare beneficiaries. Annual Enrollment has already begun, and Open Enrollment will continue through March 31, 2008.

#002: Central Health Medi-Medi Plan is exclusively for beneficiaries who have both Medicare and Medi-Cal eligibility. Dually eligible beneficiaries can enroll throughout the year.

Central Health Medicare Plan welcomes referrals of prospective Medicare enrollees from our providers and community. Please contact us for your referral and enrollment needs. Our Customer Service representatives are standing by toll-free at 1-866-314-2427.

We look forward to strengthening our outstanding presence of quality and service throughout Los Angeles and San Bernardino Counties with our network providers.

Medicare Risk Adjustment

The Centers for Medicare and Medicaid Services (CMS) establishes payments to Medicare Advantage (MA) health plans based on the health status of enrollees. This process, known as Risk Adjustment, directly affects payments to health plans and thereby impacts payments to medical groups and participating providers.

Risk scores are derived from the ICD-9-CM diagnostic codes that are reported to CMS. Only those codes with a significant cost implication to Medicare are considered "relevant" and grouped into 70 hierarchal condition categories (HCC). Each of these HCCs are designated with a potential risk score contribution value. If an enrollee is reported as having a relevant health condition, then that enrollee's risk score can potentially increase by the corresponding value of the associated HCC. For example, if an enrollee is reported as having chronic lymphocytic leukemia without remission (ICD-9 204.10), then this enrollee's overall risk score may increase by 0.69 points, which is the corresponding value for HCC9—lymphatic, head & neck, brain, and other major cancers. Within certain parameters and restrictions, an enrollee's risk score generally increases with the number of reported relevant health conditions.

Risk scores signify and predict the frequency and intensity of health care utilization, and CMS uses risk scores to evaluate and adjust the accuracy of health care payments. Risk scores essentially represent ratios of costs and payments in relation to that for the standardized Medicare beneficiary. For example, if the risk score for an enrollee is 1.69 after normalization, then the risk adjusted portion of Medicare costs and payments are 69% higher than that for the standardized Medicare beneficiary.

Data Submission

Risk adjustment is based on the health status of enrollees. As all diagnostic codes used for risk adjustment derive solely from claims and encounters submitted by Medicare providers, Central Health Medicare Plan recommends that providers accurately and comprehensive report all diagnostic codes by:

- Selecting codes with highest degree of specificity by describing complications and severity whenever possible;
- Maintaining codes for well-controlled chronic conditions that continue to affect medical management and decisions;
- Submitting all claims and encounters in a timely fashion; and
- Submitting all claims and encounters using the provider's assigned National Provider Identification (NPI) number.

Federal law requires that all claims and encounters use exclusively the NPI to identify the health care provider after May 23, 2008. Providers may request an NPI number at no cost by visiting the website: https://nppes.cms.hhs.gov.

Data Validation

CMS conducts random and focused audits of medical record documentation to ensure the integrity and accuracy of Medicare payments. Claim and encounter codes are verified against provider notes and other documentation, and discrepancies are subject to repayment and other penalties. Central Health Medicare Plan recommends that providers implement sound documentation practices including:

- Clinically confirming all diagnoses suggested in radiology, laboratory, and pathology reports from physicians who may not have directly examined the patient, and independently documenting diagnoses suggested by ancillary providers who are not licensed in the practice of medicine;

- Documenting diagnoses to the highest degree of certainty and avoiding modifiers such as "rule out," "probable," "consistent with," or "working diagnosis" whenever actual diagnoses are known or definitive treatment has been prescribed;

- Documenting all persistent conditions and avoiding descriptors such as "history of" when the condition is contemporary;

- Valid medical documentation must be legible, identify the patient, identify the date of the visit, and signed by a provider licensed to practice medicine.

Summary

Central Health Medicare Plan strongly encourages all participating providers to become knowledgeable of Risk Adjustment concepts and to participate fully in the process.

Some providers are already gaining first-hand experience as medical groups have begun to institute incentive programs based on risk adjustment. We understand that our providers commit tremendous time and resources in caring for Medicare beneficiaries, and we fully support efforts to ensure that our valued providers are remunerated for sustaining the high quality of care and attention given to our members.

Central Health Plan of California's Anti-Fraud Policy

By Kevin Lillywhite *Medicare Compliance Officer*

Central Health Plan of California, Inc. (CHPC) is committed to reducing the risk of health care fraud and abuse. To fulfill this commitment, CHPC has developed and implemented comprehensive anti-fraud policy. The key components of this policy are:

- Anti-fraud education for employees and contracted providers, including applicable laws and the importance of detection and reporting;
- Oversight and monitoring processes to detect potential fraud on the part of the Plan, its employees, contracted providers, and members;
- Prompt investigation of all instances of suspected fraud and, as necessary, reporting suspected fraud to the appropriate government or law enforcement agencies;

- Corrective Action to mitigate damage and reduce or eliminate the chance of recurrence if actual fraud is confirmed.

Summary of Key Anti- Fraud Laws

Federal False Claims Act (FCA) — The FCA prohibits any individual or business entity from knowingly submitting, or causing to be submitted, a false or fraudulent claim to the U.S. Government or contractor of the U.S. Government. Violations may be punishable by civil monetary penalties from $5,500 to $11,000 for each violation, additional penalties of up to three times the amount of actual damage (loss) to the U.S. Government, exclusion from participating in federal health care programs, and potential criminal sanctions such as imprisonment.

Program Fraud Civil Remedies Act (PFCRA) — The PFCRA prohibits individuals and entities from submitting false claims or written statements to certain federal agencies, including the Department of Health and Human Services, and generally applies to fraud amounts of $150,000 or less. Violations are subject to civil monetary penalties of up to $5,000 per incident, plus an assessment of up to twice the amount of each false claim.

United States Code, Title 18, Section 1347 — This statute establishes penalties for individuals who, in connection with delivery or payment of health care benefits, knowingly attempt to defraud any health care benefit program, or obtain compensation by false claim, statement or representation from any health benefit program. Violations are punishable by fine or imprisonment of not more than 10 years, or both.

California False Claims Act (CFCA) — The CFCA is patterned after the FCA, and is similar in intent and scope. The CFCA prohibits any individual or business entity from knowingly submitting, or causing to be submitted, a false or fraudulent claim to an agent of the State, or any political subdivision of the State such as a county or city. Violations of the CFCA are subject to civil monetary penalties of up to $10,000.

California Health & Safety Code, Section 1348(e) — This section of California law stipulates that the definition of fraud includes knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit.

"Whistleblower" Lawsuits and Protections

State and federal law permit private citizens to file lawsuits on behalf of the government if they become aware of fraud against a government health care program. Such lawsuits are known as Qui Tam or "whistleblower" actions. An individual who files a successful Qui Tam lawsuit under the FCA or CFCA may be entitled to a portion of the amount recovered by the government (15%-33% under the FCA, 15%-33% under the CFCA). Any individual who files a whistleblower suit, or reports and/or assists in any way with a false claim investigation, is protected by law from retaliatory action by his/her employer.

Common Examples of Health Care Fraud

Utilization — Providing services that are not medically necessary; Reporting inaccurate encounter or utilization data; Failing to provide medically necessary care; Offering kickbacks to health plans for assignment of healthier patients.

Claims and Billing — Billing for services not provided; Duplicate billing; Upcoding and bundling; Attempting to receive Medicare or Medi-Cal funds without current standing as a program participant.

Referrals — Making unlawful referrals to entities with which the referring provider has a financial relationship (self-referrals); Offering or receiving kickbacks from another provider in exchange for patient referrals.

Copayments / Coinsurance — Charging copayment or coinsurance amounts other than legally allowed; Failing to collect co-payment or co-insurance amounts that are due.

Beneficiary Eligibility — Falsifying enrollment or eligibility information; Using a Medicare or Medi-Cal card belonging to another individual (the legal card holder is also liable if he/she permitted such use); Using a false identity.

Beneficiary Claims Reimbursement — Seeking reimbursement for services that were not actually received from a provider; Colluding with providers to seek payment of false claims.

Central Health Plan of California deeply values the partnership of its contracted providers, not only in the provision of high-quality care to its members, but in the effort to reduce and prevent health care fraud, waste and abuse as well. If you have any questions about Central Health's anti-fraud policy, or any of the information in this above, please feel free to contact Central Health Plan's Compliance Officer by calling (626) 388-2390.

Utilization Management

Central Health Plan of California (CHPC) Utilization Management Program is developed to monitor, evaluate, and manage the quality and cost of health care services provided to our members. It is designed to coordinate medically appropriate services and achieve optimal clinical outcomes for members in the most effective manner.

The Utilization Management (UM) Committee is the oversight body for all UM activities and is chaired by the Medical Director with a minimum voting quorum of at least three physicians with unrestricted licenses to practice medicine. The CHPC UM Committee has adopted decision-making resources which include, but are not limited to, the following:

- Milliman Care Guidelines
- Medical Review Criteria Guidelines For Managed Care (Apollo)
- The Merck Manual of Diagnosis and Therapy
- Specialty Society Publications and Guidelines
- National Guideline Clearinghouse (www.guideline.gov) guidelines
- DSM IV Guidelines for Behavioral Health
- CMS Medicare Coverage Determination, Benefit, and Claims manuals
- Central Health Medicare Plan's Evidence of Coverage (EOC) and proprietary guidelines

Independent Practice Associations (IPA) and Capitated Medical Groups (CMG) may use some or all of these same resources for the UM activities for which they have delegated responsibility.

All UM decisions are based on factors such as medical necessity, appropriateness of services, and existence of coverage. CHPC does not provide financial incentives to staff and/or clinical decision-makers to encourage decisions that result in underutilization. Practitioners and/or other individuals are not specifically rewarded for issuing denials of coverage, service, or care. Members and providers may contact the UM Department for more information and copies of our UM Program, decision-making criteria, and benefit information. Utilization Management staff are available during normal business hours at (626) 388-2390 to address any routine questions or concerns. Case managers are available after-hours for emergency and inpatient care issues.

CHPC fosters a collaborative partnership with providers to help maintain the highest quality of care for our membership and the greatest satisfaction within our network. CHPC looks forward to working closely with the healthcare community in achieving the highest standards of excellence.

Quality Care and Service

Central Health Medicare Plan (CHMP) is dedicated to ensuring our members receive timely and appropriate services from our providers. To make this happen, CHMP has a written Quality Management Program designed to maintain and improve the quality of care and services. The document explains the program along with planned projects for the year. The written description of the Quality Management Program or aspects of the program is available to physicians and members upon their request.

On a yearly basis, CHMP reviews and updates Preventive Health Guidelines for prevention and early detection of diseases and illnesses. Preventive Health Guidelines are chosen for our membership and are specific to age, sex, and risk-status of members and cover the following categories:

- Cardiovascular Screenings
- Screening Mammograms
- Pap Test & Pelvic Exam
- Smoking Cessation
- Colorectal Cancer Screening
- Flu Shots
- Prostate Cancer Screening
- Pneumococcal Shot
- Hepatitis B Shots
- Bone Mass Measurements
- Diabetes Screenings
- Glaucoma Tests

Each guideline describes the prevention or early screening exams, and how often the exams are required. These guidelines are taken directly from the Center for Medicare (CMS) website. They were developed in conjunction with American Cancer Society, American Diabetes Association, and American Heart Association. To obtain a copy of the guidelines, just call our Member Service Department at 1-866-314-2427 or view the Medicare website at http://www.medicare.gov under Preventive Services.

Pre-Service Authorization

Primary Care Physicians (PCP) play a crucial role in coordinating all of the health care services required by enrollees. Services that are beyond the scope and expertise of PCPs may require pre-authorization from the enrollee's Independent Practice Association (IPA) or from Central Health Medicare Plan (CHMP). Providers who identify need for specialty services and testing should submit requests for authorization to the IPA, if applicable. Behavioral Health and Part D Pharmacy services can be requested directly from CHMP.

Organization Determinations

CHMP and its delegated IPAs review authorization requests and issue organization determinations based on established timeliness requirements. The following are **Medicare notification requirements** for initial requests of outpatient medical services:

Type of Request
Standard Initial Organization Determination (Pre-Service)
Notification Timeframe
Within 14 calendar days after receipt of request.

Type of Request
Expedited Initial Organization Determination
Notification Timeframe
Within 72 hours after receipt of request.

Delegated IPAs are required to factor in the time it takes to coordinate applicable organization determinations with CHMP to ensure that notifications are provided within timeframe.

Behavioral Health

CHMP provides Medicare covered behavioral health services. CHMP does not delegate utilization management for behavioral health services, and providers can submit requests for mental health care and substance abuse services directly to CHMP instead of the IPA. Forms and instructions are available by calling (626) 388-2390, faxing (626)388-2363, on visiting the website at *http://www.centralhealthplan.com.*

Part D Pharmacy

CHMP is pleased to cover all enrollees with Medicare Part D Prescription Drug benefits. CHMP has eliminated Step Therapy and Prior Authorization requirements for a significant number of previously restricted drugs. Providers will find that most outpatient drugs commonly prescribed to Medicare beneficiaries are on the CHMP formulary without any utilization management restrictions.

Occasionally, prescribers will be required to submit a supporting statement for drugs that are otherwise not available on the Part D formulary. The timeframe for notification of standard Part D coverage determinations is within 72 hours of receipt.

CHMP does not delegate coverage determinations for Part D Pharmacy benefits, and providers should submit requests directly to CHMP. Forms and instructions are available by calling (626) 388-2390, faxing (626) 388-2363, or visiting the website at http://*www.centralhealthplan.com.*