CENTRAL HEALTH PLAN OF CALIFORNIA

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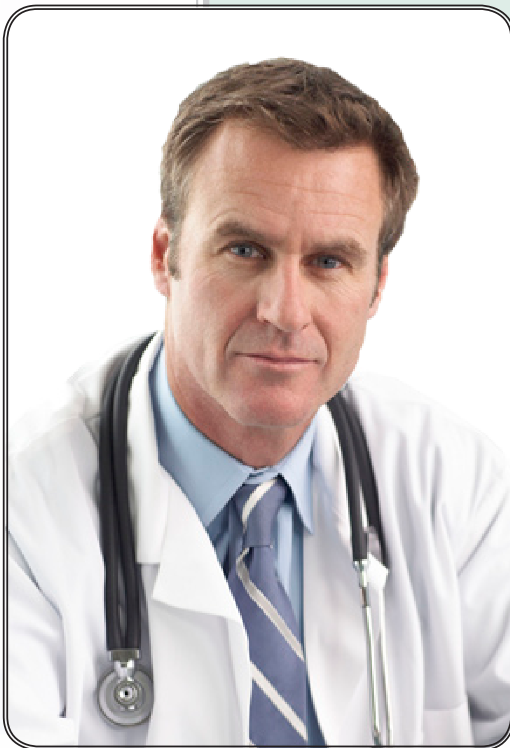
CENTRAL HEALTH E- NEWS



2009 ISSUE

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2010 Plan Offerings

Marketing

For 2010, Central Health Plan of California (CHPC) continues to offer Medicare Advantage with Prescription Drugs (MA-PD) plans that provide a variety of benefits tailored to meet the individual needs of Medicare beneficiaries. Each of the three plans listed below provides our members with cost savings for Medicare premiums, office visits, hospital stays, and/or prescription drugs.

Central Health Medicare Plan (MA-PD, Plan 001)

CENTRAL HEALTH MEDICARE PLAN HMO

Central Health Medicare Plan is available to all Medicare eligible beneficiaries. Members pay $0 cost-sharing for most of the Plan-covered services and enjoy a monthly Medicare Part B premium reduction of $18. Members pay $0 for generics, $20 ~ $40 for brand drugs, and receive full formulary coverage through the coverage gap (donut hole). As an enhancement, members also have coverage for Medicare excluded sedatives and erectile dysfunction agents.

Central Health Medi-Medi Plan (MA-PD SNP, Plan 002)

CENTRAL HEALTH MEDI-MEDI PLAN HMO

Central Health Medi-Medi Plan is a Special Needs Plan designed to accommodate the lifestyle of low income Medicare beneficiaries with Medi-Cal. Members enjoy $0 cost-sharing for Plan-covered inpatient and outpatient services, as well as coverage for many benefits eliminated by Medi-Cal, including dental, vision, hearing, chiropractic, podiatry, acupuncture, psychology, and speech therapy. Members also receive door-to-door transportation to medically necessary locations up to 20 round trips a year.

Central Health Value Plan (MA-PD, Plan 003)

CENTRAL HEALTH VALUE PLAN HMO

Central Health Value Plan is a new product offering for calendar year 2010, and is available to all Medicare eligible beneficiaries. This plan combines all the benefits of Original Medicare and prescription drug coverage with a monthly Medicare Part B premium reduction of $68. Members enjoy premium savings up to $816 a year!

The savings and benefits don't stop here! All our members are covered up to $50,000 for emergent and urgent care when they travel. No matter where they go, CHPC has them covered.

Important Enrollment Dates to Remember

November 15

Medicare beneficiaries may begin enrolling for Part D coverage or may switch health plans for a January 1, 2010 effective date.

December 31

This is the last day for Medicare beneficiaries to enroll in Part D coverage for year 2010. If Medicare beneficiaries do not choose a plan that provides drug coverage by December 31, they may not be able to obtain drug coverage.

January 1 through March 31

Medicare beneficiaries who are already enrolled in Part D coverage have an additional opportunity to switch plans. However, the option Medicare beneficiaries select must include prescription drug coverage. The beneficiary cannot add or drop Part D coverage in this period.

March 31

After this date, Medicare beneficiaries are “locked in” to their chosen health plan coverage for the remainder of 2010 (exceptions apply)*.

**Exception:*

Medicare and Medi-Cal (Medi-Medi) beneficiaries can enroll and disenroll on a monthly basis.

Marketing Support

We want to remind you that dedicated Marketing support is just a phone call away! Our Marketing representatives are fully trained on the latest CMS Marketing Guidelines and licensed by the California Department of Insurance. If your senior patients inquire about their health plan choices or desire more information about our plan offerings, please refer them to us by calling our toll-free number, **1-866-314-2427.** Our representatives are available 7 days a week, 8:00 am - 8:00 pm (PST).

Filling the Doughnut Hole in Medicare Part D

Marketing

Medicare prescription drug coverage (Part D) is coverage that adds to, or is included with, a beneficiary's Medicare health care coverage. Part D coverage helps a beneficiary pay for drugs that he needs. Any beneficiary with Medicare is eligible to enroll in Part D.

A unique feature of the Medicare prescription drug benefit is the coverage gap, commonly referred to as the "doughnut hole." Above a certain threshold, Medicare's coverage of monthly spending on prescription drugs stops, only to resume at a higher "catastrophic" threshold.

Each drug plan has its own set of criteria, premiums, and coverage options for Part D. In 2010, the coverage must be no worse than the following baseline, based on a beneficiary's total drug spending: no coverage for the first $310 (deductible); from $310 to $2,830, Medicare covers 75%; from $2,830 to $4,550, the coverage gap (doughnut hole) kicks in with 0% coverage; above $4,550, coverage maxes out at 95%.

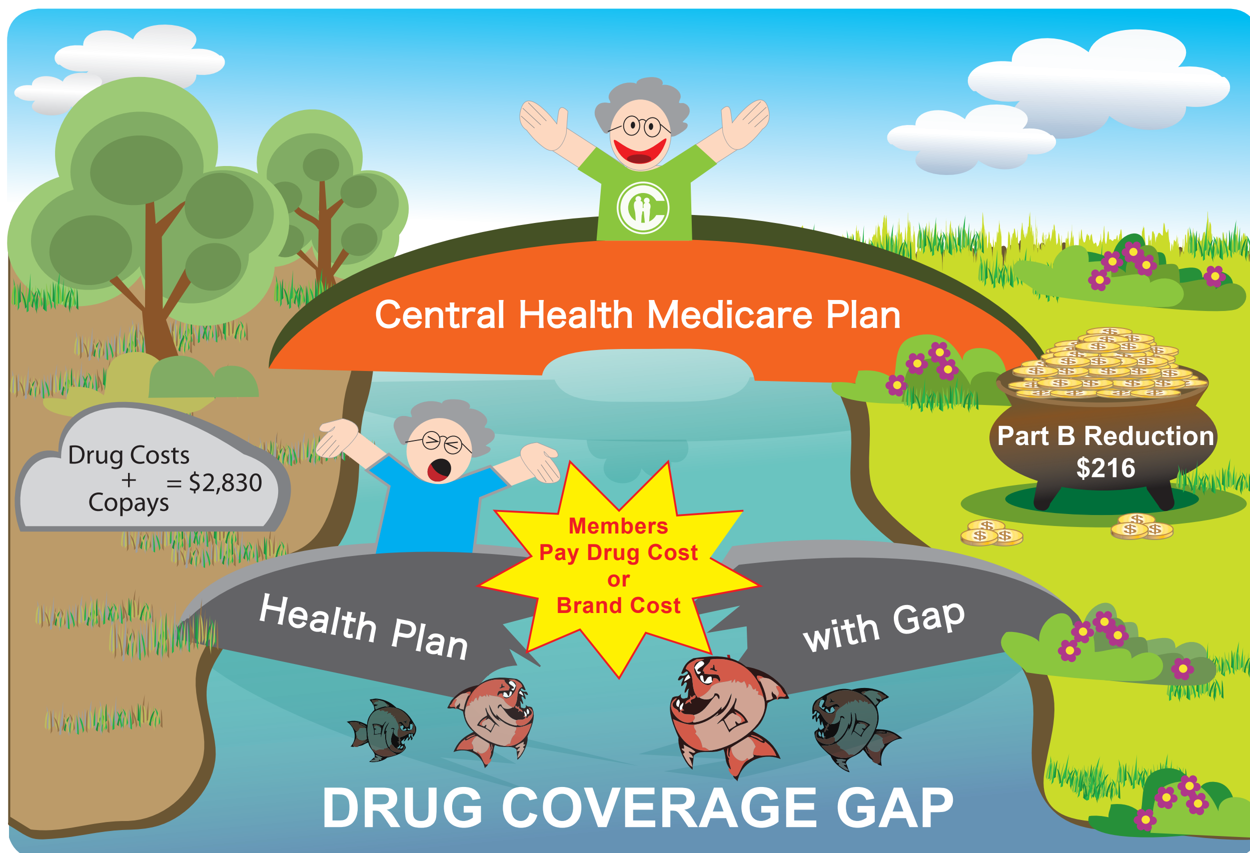
The majority of Medicare drug plans in the marketplace either does not have gap coverage or offers partial coverage limited to generic drugs and select brands. A beneficiary can potentially be looking at a $1,720 doughnut hole ($4,550 minus $2,830) while in the gap. The financial impact can be devastating and potentially lead to skipping doses, pill splitting, and/or failing to fill prescriptions.

Central Health Medicare Plan (HMO) is one of three health plans in Southern California to offer full drug coverage (generics and brands) through the gap. Estimated monthly savings for select drugs are listed in the table below to illustrate our drug benefit.

Payment Differences Between Plans With and Without Brand Drug Gap Coverage			
Brand Drugs Prescribed	**Central Health Medicare Plan**	**Plans Without Brand Drug Gap Coverage**	**Plans Without Brand Drug Gap Coverage**
	Payment / Month	Payment / Month*	Payment / Year*
Lipitor	$20	$130	$1,560
Cozaar	$20	$ 50	$ 600
Actos	$40	$220	$2,640
Actonel	$40	$275	$3,300
Plavix	$40	$160	$1,920
Flomax	$20	$120	$1,440

*Costs are approximate.

Out of the three health plans that offer full drug coverage, Central Health Medicare Plan is the ONLY plan to offer a Part B premium subsidy of $18 per month. Members can save up to an additional $216 a year! Remember: There is coverage available to fill the doughnut hole, and you can help your patients enroll in Central Health Medicare Plan to bridge that gap.



2010 Formulary

Pharmacy

Effective January 1, 2010, Central Health Plan of California (CHPC) will be making some changes to the formulary.

Common Drugs that are being restricted

Brand-name drug	Used for	Generic drug(s) to consider
Actonel®	Osteoporosis	Generic: alendronate (generic Fosamax®)
Lipitor® Crestor® Lescol®, Lescol XR®	Dyslipidemia	Generic: lovastatin (generic Mevacor®) simvastatin (generic Zocor®) pravastatin (generic Pravachol®)
Aciphex® Nexium®	GERD	Generic: omeprazole (generic Prilosec®)

Drugs that are being removed

Brand-name drug	Used for	Other preferred drug(s) to consider
Prevacid®	GERD	Generic: omeprazole (generic Prilosec®)
Boniva®	Osteoporosis	Generic: alendronate (generic Fosamax®)
Tricor®	Dyslipidemia	Generic: fenofibrate

Drugs that require Step Therapy*

Step 1 Medications	Step 2 Medications
NSAIDS	Arthrotec®, Celebrex®,
Galantamine	Aricept®
Simvastatin, lovastatin, pravastatin	Lipitor®, Crestor®, Lescol®, Lescol XL®
Oxybutynin	Detrol LA®, Detrol®, Vesicare®
Doxazosin, terazosin	Flomax®
Finasteride	Avodart®
Flovent®, Pulmicort®	Advair®
Fluticasone spray	Singulair®
Cozaar®, Hyzaar®	Diovan HCT®, Avapro®, Avalide®, Atacand HCT®, Micardis HCT®
Sulfonylureas, metformin	Januvia®, Janumet®
Sulfonylureas, metformin	Byetta®
OTC Prilosec®, omeprazole	Aciphex®, Nexium®
Methadone, Morphine Sulfate	Avinza®, Kadian®
Zolpidem	Ambien CR®, Rozerem®, Lunesta®

*Step Therapy requires an adequate trial of step 1 drug(s) before a step 2 drug will be covered.

Drug Formulary

The CHPC formulary is printed and distributed annually by direct mailing to practitioners, contracted pharmacies and new members. It is also made available to practitioners, pharmacists and the public upon request. The formulary is also displayed on the CHPC web site.

Notification of Formulary Changes

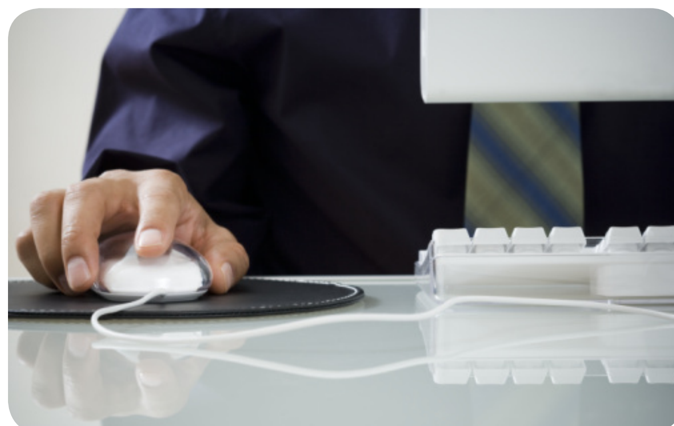
CHPC will provide notifications of changes to authorized prescribers, network pharmacies, and pharmacists at least 60 days prior to the date of removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the plan shall provide retrospective notice to the parties listed above.

Eligibility Verification Made Easy

Provider Relations

Web Access

Central Health Plan of California (CHPC) makes it easy to verify eligibility through our web site. This online provider tool is a simple method to obtain needed information about CHPC members and benefits, 24 hours a day, 7 days a week. Please call Provider Relations at (626) 388-2390 or send us an email to providerupdate@centralhealthplan.com to request a Web **Authorization Form.** Upon completion and submission of this form, you will be assigned a user ID and password.



Interactive Voice Response (IVR) system

CHPC makes it easy for our providers to verify member eligibility through the use of one toll-free phone number. The Interactive Voice Response (IVR) system is a dedicated provider number to ensure a simple method to obtain needed information about CHPC members, benefits and services, 24 hours a day, 7 days a week. For setup, please contact CHPC Information Services department at (626) 388-2390.

Please call the IVR Automated Member Eligibility / Benefit Line at (800) 738-7850.

HCC Risk Score Management

Risk Adjustment

Since 2007, the Centers for Medicare and Medicaid Services (CMS) has fully implemented a payment system to health plans that is based on enrollees' relative health status. CMS developed a Risk Adjustment model that uses Hierarchical Condition Categories (HCC) to predict the medical costs of beneficiaries. Each calendar year, enrollees are assigned a "Risk Score" based on the diagnosis codes that physicians submit for their patients during that calendar year.

This Risk Adjustment payment model already impacts Medicare payments to health plans, and IPAs, and medical groups. This model is anticipated to impact all provider and physician payments soon. Central Health Plan of California (CHPC) is pleased to actively assist our valued providers in preparing for this impact of Risk Adjustment on your business.

There are several key principles that can help providers and physicians improve HCC scores and Medicare payments.

- Evaluate all members for all chronic conditions every year.
    - Reassess all established members.
    - Call new members for an appointment.
    - Remember to evaluate HCC diagnostic codes from previous years. Most often, chronic (not acute) conditions have HCC scores.
    - Evaluate and report brand new or newly chronic conditions.

- Support all ICD-9-CM codes with documentation.
    - All documentation must clearly display physician credentials, signature, and date of service.
    - Lab data, X-ray reports, and pathology reports without evaluating or treating physician interpretation cannot be coded.
    - Avoid using "history of," "rule out," "probable," "suspect," "consistent with," "working diagnosis," or "status-post" when diagnosis is clearly established or when definitive treatment is starting.

- Use the most specific or complete codes.
    - Sometimes it may be appropriate to combine two or more conditions into one code when both conditions occur together or when one is a manifestation of the other. These additional codes may have HCC risk score value.
        - Pay attention to “code also,” which suggests that a related code might further explain the exact nature of the condition
        - Pay attention to Diabetes as this condition is often associated with known chronic co-morbidities.
        - Pay attention to other conditions often associated with co-morbidities:
            - chronic kidney disease
            - heart failure and arrhythmia
            - vascular disease
            - depression
            - liver disease
            - asthma and bronchitis
    - Document relationships between co-morbidities by using terms like “due to,” “secondary to,” or “associated with.”

- Review the updated ICD-9-CM diagnostic codes every October.
    - Replace expired codes with new codes.

CHPC is on the forefront in helping providers successfully implement business practices in preparation for the impact of Risk Adjustment. CHPC exclusively publishes the ***Medicare Risk Adjustment – Desktop Reference and the Medicare Risk Adjustment – Pocket Reference*** to assist providers and physicians find ICD-9-CM codes with the highest HCC score supported by the documentation. CHPC has also published and mailed a ***Risk Adjustment Super Bill*** to make it easier for providers to review, document, and report chronic conditions for each and every member.

CHPC has begun scheduling education conferences and personal physician office visits to help physicians understand and manage Risk Adjustment and to review medical documentation and coding practices for revenue opportunities. Central Health Medicare Plan cares about its providers. To learn about these Risk Adjustment programs, please contact Pao Chiang Lu, M.D., at pclu@centralhealthplan.com or 1-626-388-2390 extension 3845.

Quality Care and Service

Quality Management

Central Health Plan of California (CHPC) is dedicated to ensuring our members receive timely and appropriate services from our providers. To make this happen, CHPC 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, CHPC embarks on a Quality Improvement Project (QIP), clinical or non-clinical, that is expected to have a favorable effect on health outcomes and/or enrollee satisfaction. Each one is carried out for a period of three to four years depending on whether measurable improvement is achieved or not on the third year.

We are now in the process of winding down our 2007 QIP entitled "Improving Compliance with Diabetes Care" because analysis of our 2009 Healthcare Effectiveness Data Information Set (HEDIS) audit results showed increases in patient encounter data for all four quantifiable measures compared to 2008; LDL-Cholesterol screening, HbA1c Testing, Eye Exam, and Nephropathy Screening.

Our 2008 QIP entitled "Improving Member Satisfaction by Appropriately Identifying and Addressing Appeals and Grievances" is now in its second year. Aggregated data show that CHPC is becoming more efficient in dealing with member complaints which we hope will result in increased member satisfaction as should be shown in the upcoming Consumer Assessment of Health Plans and Systems (CAHPS) survey in November 2009.

This year, our QIP is entitled "Improving Beneficiaries' Access to Care by Improving HEDIS Rates for Medication Reconciliation Post-discharge (MRP) and Care for Older Adults (COA)." MRP requires proper documentation in the patients' medical records of all medications prescribed or ordered upon discharge from an acute (hospital) or non-acute (Skilled Nursing) facility within 30 days of the discharge. COA requires proper documentation in the patients' medical records of each of the following; Advanced Care Planning, Medication Review, Functional Status Assessment, and Pain Screening.

Each QIP is developed in compliance with the Centers for Medicare and Medicaid Services (CMS) regulations. To obtain a copy of the documents, just call our Quality Management Department at 1-866-314-2427.

Utilization Management

Central Health Plan of California (CHPC) Utilization Management Program is designed 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:

- CMS Medicare Coverage Determination, Benefit, and Claims manuals.
- CHPC's Evidence of Coverage (EOC) and internal guidelines
- 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

CHPC delegates utilization management activities to many of its contracted medical groups that meet the Plan standards for delegation. The Plan, however, has overall accountability and responsibility for oversight. Capitated Physician Groups (CPGs) delegated for UM activities may develop additional clinical criteria for use within their system, but they must be reviewed and approved by CHPC prior to their implementation.

All authorization decisions for benefit coverage and medical necessity are consistent with sound clinical principles and processes and are based on, but not limited to, review of medical records, consultation with treating practitioners; and review of recognized criteria. **UM decision-making is based only on appropriateness of care and service and existence of coverage. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage or service. Financial incentives for UM decision-making do not encourage denials of coverage or service or decisions that result in underutilization.**

CHPC provides access to staff for members and practitioners seeking information about the UM process and the authorization of care. CHPC staff are available during normal business days/hours to respond to inquiries about the utilization process and the authorization of care. During after hours and holidays, CHPC maintains telephone access to providers and members with on-call nurses.

CHPC may copy criteria for each practitioner, members or their representatives, read them over the phone or distribute them via the internet. Clinical information, criteria and guidelines used for decision making are communicated to providers in a timely manner as necessary.

CHPC has mechanisms in place to evaluate member and practitioner satisfaction with the utilization management process. Member complaint and satisfaction surveys tracking and trending is utilized as well as the annual CAHPS Member Satisfaction Survey. CHPC's Physician survey is utilized to assess practitioner satisfaction. The results of this annual survey along with the results of the Member Satisfaction survey and member complaints are reviewed to identify drivers of dissatisfaction. Barrier analysis is performed to determine root causes, and opportunities for improvement are identified and interventions implemented as indicated.

HIPAA / HITECH Breach Notification Rule General Analysis

Compliance

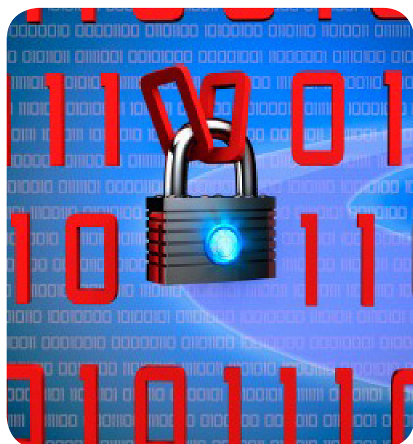
Background

In accordance with HIPAA Privacy and Security Rules, covered entities (CE) and business associates (BA) are required to protect the privacy of health information and provide individuals with certain rights with respect to their health information.

On August 24, 2009, the Secretary to the Department of Health and Human Services (DHHS) issued interim final rules on HIPAA's new security breach notification requirement, which was adopted under the Health Information Technology for Economic and Clinical Health (HITECH) Act in February as part of the American Recovery and Reinvestment Act (ARRA). The new HITECH Act has substantially expanded the scope of HIPAA regulations as well as increased the amount of penalties for non-compliance.

GUIDANCE ON HITECH BREACH NOTIFICATION REQUIREMENTS

What does the HITECH breach notification rule say?
Covered entities and their business associates are subject to these HITECH breach notification requirements. The general rule is if a CE discovers a breach of unsecured PHI, it must notify each individual whose unsecured PHI has been, or is reasonably believed to have been accessed, acquired, used or disclosed as a result of such breach.



What is Protected Health Information (PHI)?

PHI means individually identifiable health information that is transmitted or maintained in electronic media or any other form or medium. PHI includes member / subscriber / patient's information such as: name, address, dates [birth date, admission, discharge, etc], social security number, medical record numbers, phone and fax numbers, e-mail, health plan beneficiary numbers, account numbers, certificate / license number, license plate number, finger and voice prints, full face photo, and other unique identifying number, characteristic, or code.

What is unsecured PHI and how do you keep PHI secure?

CEs must only provide the required notification of breach to the impacted member if the breach involved *unsecured* PHI.

Unsecured protected health information means PHI that has not been rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by DHHS. DHHS has identified encryption and destruction as two methods to secure PHI from unauthorized access and use. For information on DHHS guidance on how to keep PHI secure to avoid unauthorized access and use in violation of the HIPAA Privacy / Security Rules, please visit the following link: http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/federalregisterbreachrfi.pdf

Under the HITECH breach notification rule, what does "breach" mean?

Breach means the acquisition, access, use, or disclosure of protected health information in a manner not permitted by the HIPAA Privacy and/or Security Rules which compromises the security or privacy of the protected health information.

Are there exceptions to the breach notification rule?

Yes. The HITECH Act includes three exceptions to the definition of "breach" that encompass situations Congress clearly intended to not constitute breaches:

1. Unintentional acquisition, access, or use of protected health information by a workforce member or person acting under the authority of a CE or a BA, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under the HIPAA Privacy / Security rule.

2. Inadvertent disclosure by a person who is authorized to access PHI at a CE or BA to another person authorized to access PHI at the same CE or BA, or organized health care arrangement in which the CE participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under the HIPAA Privacy and/or Security Rules.

3. Unauthorized disclosure of PHI where a CE or BA has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

RISK ASSESSMENT GUIDANCE

How do I determine if a "Breach" has occurred?

To determine if an impermissible use or disclosure of PHI constitutes a breach, CEs must perform a risk assessment to determine if there is "a significant risk of financial, reputational or other harm to the individual" as a result of the impermissible disclosure use or disclosure.

It is important to document that risk assessment was completed in order to demonstrate, if necessary, that no breach notification was required following an impermissible use or disclosure of PHI.

What questions should I ask in conducting a Risk Assessment?

Some factors to consider in conducting a risk assessment include the following questions:

- Who impermissibly used the information and to whom the information was impermissibly disclosed
- Whether any immediate steps have been taken to mitigate an impermissible use or disclosure of PHI
- Whether the PHI disclosed was returned prior to being accessed
- The type and amount of PHI involved in the disclosure
- The risk of re-identification of PHI contained in a limited data set

SECURITY BREACH NOTIFICATION GUIDANCE

Notification to Individuals.

a. Timeliness of Notification. CEs must provide notification of PHI breaches to affected individuals **without unreasonable delay** and in no case later than 60 calendar days from discovery of the breach. ***If the breach was caused by the business associate it must notify the CE immediately.*** NOTE: The clock starts ticking on the day that a workforce member discovers the breach, so it is imperative that potential breaches be forwarded to the CE's Privacy Officer immediately.

How do I notify the impacted individual of the breach?

Following a breach of unsecured PHI, CEs must provide notification of the breach to affected individuals, the Secretary of DHHS and, in certain circumstances, to the media.

b. Content of Notification. The notification sent to affected individuals must be in plain language and must include the following, to the extent possible:
    i. Description of what happened, including date of breach and date of discovery of breach, if known;
    ii. Description of types of unsecured PHI that were breached (e.g., name, SSN, DOB, address, account number, diagnosis, etc.);
    iii. Steps individuals should take to protect themselves from harm;
    iv. Description of what the CE is doing to investigate the breach, to mitigate harm to individuals whose PHI was breached, and to protect against future breaches; and
    v. Contact information for individuals to get additional information (must include toll-free number, email address, Web site, or postal address).

c. Methods of Notification. The notification sent to affected individuals must be in writing via first-class mail, or electronic mail if the individual has agreed to such notice. In urgent situations where the CE deems that misuse of unsecured PHI is imminent, the CE may also telephone the individual.

What should I as a covered entity do to be in HIPAA / HITECH Compliance?

The new HITECH provisions require DHHS to conduct periodic audits of both CEs and BAs to ensure HIPAA compliance. If you face an audit from DHHS next month, how would you fare with the new HITECH regulations? For starters, here are some items that providers can do to ensure HIPAA / HITECH compliance:

1. **Develop / Revise existing Policies and Procedures** to comply with HIPAA Privacy / HITECH breach notification requirements
2. **Training.** Train your staff with new / revised HITECH / HIPAA Privacy compliance policies and procedures. Central Health Plan is dedicated to providing educational resources to its providers.
3. **Business Associate Agreements.** Revise your business associate agreements if necessary to ensure they comply with the new HITECH regulations.
4. **Sanctions.** Develop, apply, and document sanctions to whoever in your office violates the privacy policies and procedures.

HIPAA Enforcement: How much will missteps cost me and my organization?

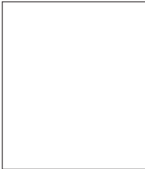
Section 13410 of HITECH authorizes the Office of Civil Rights (OCR) to collect Civil Monetary Penalties (CMP) for non-compliance with HIPAA privacy violations. The CMPs range from $100 to $50,000 for each violation, depending on the severity of the HIPAA violation. For violations of willful neglect that the organization did not correct, OCR can impose $50,000 fine for each violation, with a maximum of $1.5 million per calendar year for multiple violations of one requirement.

The HITECH Act also allows states' attorney generals to levy fines and seek legal fees from covered entities on behalf of victims. Courts now have the ability to award costs, which they were previously unable to do.

Web sites:

If you need additional guidance or want to find valuable resources to achieve your HIPAA/HITECH compliance, please go to the following resources:

- http://edocket.access.gpo.gov/2009/pdf/E9-20169.pdf
- http://www.cms.hhs.gov/HIPAAGenInfo
- http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/index.html



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