CENTRAL HEALTH MEDICARE PLAN

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2010 ISSUE

CENTRAL HEALTH E - NEWS

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A Message to Our PCPs

How The Health Reform Affects Medicare Advantage Organization and PCPs

Health reform has brought forth major financial changes to Medicare Advantage (MA) HMO and PPO organizations across the nation. The reform will reduce MA spending by $132 billion and overall Medicare spending by $500 billion over the next 10 years.

To achieve this drastic financial cutback, CMS has made the following payment reduction to MA Organizations:

1. Reduces premium payment to MA HMO by 13% starting 2011
2. Reduces HCC risk score payment by 3.41% starting 2011 and further reduces to 5.46% by 2017
3. Decreases rebate dollars to HMO by 5% to 25% depending on the Star score; ("Rebate" is the profit remaining when the cost of a MA plan is lower than the CMS benchmark; rebate dollars can only be used for the sole purpose of patient benefits enhancement)

It is estimated that by 2017, most of the plans will have a reduction of about 18% in their CMS payment. Since the IPA and hospital risk pools are paid as a percentage of HMO premium (e.g. 38%/38%); IPA revenues will also drop proportionally as the immediate impact. PCP payment from IPA will certainly be affected at that time, if not sooner.

There are only two ways for an MA HMO to improve revenue by a small amount:
(1) CMS bonus and, (2) Increasing HCC risk score

CMS Bonus – Through "Star System"
CMS allocated about 1% of the plan payment as incentive for quality. Currently, CMS uses a "Star System" to evaluate plan quality with 5 stars as the best and 1 star the worst. There are two Star score components, Part C (medical) and Part D (pharmacy). Part C has 33 measures which are mostly related to HEDIS criteria. Part D has 18 measures.

A plan with 4 stars or more (only 10% of the plans) will be eligible for a 5% bonus from CMS. The Star average score for HMOs throughout the United States is 3.3; nonprofit plans at 3.8 and for profit plans at 3.0. Three of the local largest HMOs are all between 2.8 to 3.2. Furthermore, when a plan has less than 3.5 Stars, the rebate dollar will be decreased by 25%, 10% between 3.5 and 4.5 Stars and 5% decrease if >4.5 Stars. Most of the plans, if not all, are now focusing on improving HEDIS and CMS Chronic Condition Interventions compliance in an attempt to increase their Star scores.

HCC Risk Score
Other than the CMS Star bonus, the only other way for the HMO/IPA/PCP to increase revenue is through increasing the HCC score. However, according to industrial statistics, the increase usually will plateau out after 3 years of continuous effort. CMS will also try to counteract the increase by a 3.41% payment reduction in 2011 and 5.46% in 2017.

Central Health Medicare Plan (CHMP) will distribute to our PCPs and members the CMS Screening and Chronic Condition Intervention guidelines shortly. We encourage our PCPs and members to work together to complete these screenings and achieve the Chronic Condition treatment goals. The future for Medicare is quality and only by working together can we win this Star War.

Central Health Medicare Plan Wins Senior Choice Gold Award Again!

Central Health Plan of California is proud to announce that Central Health Medicare Plan (HMO) has been awarded the prestigious 2011 Senior Choice Gold Award for "Excellence in Medicare Benefits Value" in Los Angeles County and Orange County. This is the second time that this honor has been bestowed upon our plan. The recognition was made by HealthMetrix Research, a national independent managed care research firm, which compares Medicare Advantage plans across the U.S. on an annual basis. HealthMetrix Research awards one plan in each major market for having the best overall value by analyzing how health plans design their medical and prescription drug benefits. These benefits are compared to the average out-of-pocket costs for Medicare beneficiaries in three hypothetical health categories – GOOD, FAIR, or POOR health. Central Health Medicare Plan came in first against all other plans in the Los Angeles County and Orange County markets by having the lowest cost-sharing in all categories. For more information on the award and the full press release, please visit www.MedicareNewsWatch.com.

2011 Plan Offerings

Marketing Department

Central Health Plan of California is adding two brand new benefits to our 2011 benefit offering – comprehensive dental and over-the-counter coverage.

Comprehensive dental is provided by Liberty Dental Plan. Our members automatically receive coverage for services including diagnostic, preventive, restorative, endodontics, periodontics, prosthodontics, and oral surgery. There are no additional premiums, deductibles, copayments, or enrollment forms to complete.

Over-the-Counter (OTC) provides our members a monthly allowance of either $12 (Plan 001) or $18 (Plan 002) to purchase medicine and first aid supplies at local pharmacies. Commonly used OTCs covered by this benefit include, but are not limited to, antihistamines, analgesics, topical antibiotics, cold and flu, decongestants and sinus, cough suppressants and expectorants, dental and denture care, sleep aids, and topical steroids.

Two different plan offerings are available to Medicare beneficiaries:

CENTRAL HEALTH MEDICARE PLAN HMO

Plan 001 – Central Health Medicare Plan (HMO) is available to all Medicare beneficiaries. Open enrollment starts November 15 and ends December 31, 2010. The second enrollment period that historically starts January 2011 and ends March 31 has been eliminated by health care reform. Central Health Medicare Plan is open for enrollment to residents in Los Angeles County, Northern Orange County, and Southwestern San Bernardino County.

CENTRAL HEALTH MEDI-MEDI PLAN HMO

Plan 002 – Central Health Medi-Medi Plan (HMO SNP) is designed exclusively for beneficiaries who have both Medicare and Medi-Cal eligibility. Dually eligible beneficiaries can enroll year-round without restrictions. Central Health Medi-Medi Plan is open for enrollment to residents in Los Angeles County and Southwestern San Bernardino County.

We welcome referrals of prospective Medicare enrollees from our providers and community. Please contact us for your referral and enrollment needs. Our representatives are standing by toll-free at 1-866-314-2427, 7 days a week, from 8 A.M. to 8 P.M. (PST). We look forward to strengthening our outstanding presence of quality and service with our network providers throughout our service area.

Member Satisfaction: A Big Factor in Medicare Reimbursements

The repercussions of the economic crunch and the dwindling Medicare funds are knocking at our doorsteps. The Centers for Medicare and Medicaid Services (CMS) is actively measuring the amount and quality of services we render to Medicare beneficiaries through the Healthcare Effectiveness Data Information Set (HEDIS). CMS also measures our members' satisfaction with our primary care and specialist providers through two yearly surveys, the Health Outcomes Survey (HOS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

As CMS will start reducing the amount of reimbursements using the "Star Rating System," the ratings are based on the measures and surveys mentioned above. The Star Rating System will definitely affect the bottom lines of the Plans, the IPAs and you, the Providers.

In order to give you an idea of how the member surveys are conducted, we have extracted some of the key questions used pertaining to physician services. Our members' answers to these questions are determined by how they perceive their encounters with you. We ask that you be aware of these questions and document your discussion with the members in their charts.

CHMP appreciates your efforts in providing high quality services to our mutual Medicare members.

Health Outcomes Survey (HOS) Questions

Doctor discussed the following questions with the member during their visit:

- Urine leakage problem
- Treatment of urinary incontinence to include bladder training, exercises, medication and surgery
- Level of exercise or physical activity
- Advise you to start, increase or maintain your level of exercise or physical activity
- About falling or problems with balance or walking
- Prevent falls or treat problems with balance or walking. Some things they might do include: Suggest cane or walker, exercise program, vision or hearing test, checking blood pressure lying or standing
- Bone density test to check for osteoporosis

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Areas that members are surveyed base on their experience at the time of their Doctors visits

PATIENT-PCP & SPECIALIST INTERACTIONS	COORDINATION OF CARE
• Doctor explanations understandable • Doctor listens carefully & shows respect • Doctor instructions understandable • Doctor spends enough time	• Doctor office follow-up of test results • Doctor informed & up-to-date about the care you received from specialist
PATIENT ACCESS	**HEALTH PROMOTIONS**
• Visit starts within 15 minutes of appointment (waiting + exam room) • Got advice after regular office hours	• Doctor discussed your eating habits • Doctor advised you to quit smoking • Doctor discussed exercise

Access to care standards

STANDARD	PCP	SCP	BEHAVIORAL HEALTH	
Telephone Access	30 seconds	30 seconds	Life-threatening emergency	Immediately or direct to nearest ER
Preventive	30 days		Non-life threatening emergency	Within 6 hours
Routine	7 days	14 days	Urgent Needs	Within 48 hours
Urgent Care	24 hours	24 hours	Routine office visit	Within 10 working days
Emergent Care	Immediately	Immediately	Telephone Access	Within 30 seconds
Wait Time	15 minutes	15 minutes	Waiting time in office	15 minutes

Practice Guidelines for CMS Compliance

The Centers for Medicare and Medicaid Services (CMS) require the plan and providers to furnish all Medicare beneficiaries with **Preventive Care Screenings** and receive appropriate **Interventions for Chronic Diseases**.

To comply with CMS guidelines, we have created a quick reference guide that will assist you in identifying the necessary screenings to meet the preventive care goal and interventions for their chronic conditions. CHMP will notify our members of these requirements and advise them to make an appointment with their respective primary care physician.

Central Health Medicare Plan (CHMP) appreciates your commitment in assuring high quality services for our members.

Medicare Recommended Screenings for ALL Seniors

Screenings	Frequency
Services Performed by PCP	
1. Physical Activity Measurement (Advise patient to start, maintain or increase exercise)	Yearly
2. Blood Pressure Monitoring (Goal: BPs < 140, BPd < 90)	Yearly
3. Flu Vaccine (September to December)	Yearly
4. Pneumococcal Vaccine	One time
Services Referred by PCP	
1. Mammogram (Up to age 69)	Every 2 years
2. Glaucoma Screening (Optometrist or Ophthalmologist)	Yearly
3. Osteoporosis (Bone density test)	One time
4. Colorectal Screening; Colonoscopy OR Stool OB x 3 (for patient who never had colonoscopy)	Every 10 years Yearly

Medicare Recommended Interventions for Chronic Conditions

Conditions	Interventions & Goals
1. Diabetes	a. Yearly LDL-C < 100 b. Yearly HbA1C < 9.0 (Ideal < 7.0) c. Latest BPs < 140, BPd < 90 d. Yearly eye exam by Optometrist/ Ophthalmologist e. Yearly urine microalbumin f. Use of ACEI* or ARB* for BP control
2. New Bone Fracture in Women	1. Treat with anti-osteoporosis drug (e.g. Fosamax) within 6 months 2. Bone density test within 6 months 3. Fall instructions
3. Hypertension	Latest BPs < 140, BPd < 90
4. Rheumatoid Arthritis	Treat with at least one disease modifying drug, e.g. sulfasalazine, hydroxychloroquine
5. New COPD	Confirm with Spirometry test within 12 months
6. C/O Urinary Incontinence	Advise & treat within 6 months of diagnosis & document in chart
7. History of Fall or Imbalance	Advise & fall intervention within 12 months & document in chart
8. Post Acute MI, CABG, PTCA, or Ischemic Vascular Disease	Yearly LDL-C < 70
9. Patients on the following drugs; a. Digoxin, b. Diuretics c. ACEI* / ARB*	Yearly BMP including K+, BUN, Cr
10. Patients on Anticonvulsants	Yearly serum concentration of anticonvulsants

*ACEI – Angiotensin Converting Enzyme Inhibitor
*ARB – Angiotensin Receptor Blocker

Utilization Management

Utilization Department

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

The CHMP UM Committee has adopted decision-making resources which include, but are not limited to, the following:

- CMS Medicare Coverage Determination, Benefit, and Claims manuals
- Central Health Medicare Plan'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

CHMP 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. Participating Physician Groups (PPGs) are delegated to perform UM activities and may develop additional clinical criteria for use within their system, but they must be reviewed and approved by CHMP prior to implementation.

All determinations are based on benefit coverage and medical necessity which are consistent with sound clinical principles and processes, including the 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.**
- **CHMP does not specifically reward practitioners or other individuals for issuing denials of coverage or service.**
- **CHMP does not offer financial incentives to influence UM decision making which may lead to denials of coverage, service, or decisions that result in underutilization.**

CHMP UM Personnel are available during normal business hours to respond to inquiries about the UM process from members, practitioners, and PPG's. During after hours and holidays, CHMP maintains telephone access to providers and members with on-call nurses.

CHMP 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.

CHMP evaluates member and practitioner satisfaction with the UM process. Member complaint and satisfaction surveys tracking and trending are utilized along with the annual CAHPS Member Satisfaction Survey. Physician surveys are utilized to assess practitioner satisfaction. The results of the satisfaction surveys 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.

New Training Requirement on Fraud, Waste, and Abuse

Compliance Department

As required by the Centers for Medicare & Medicaid Services (CMS), all employees, contractors and officers of organizations providing Medicare Part C and D services must complete a Fraud, Waste & Abuse (FWA) general training program. As such, Central Health Medicare Plan (CHMP), and its first tier, downstream and related entities participating in its network are required to participate in FWA training each year. The purpose of the training is to prevent, identify and report fraudulent, wasteful, and abusive activities from occurring.

To ensure that CHMP's providers meet this training requirement, you may access the FWA Training materials by visiting our website at: www.centralhealthplan.com and by clicking on **"Provider"** tab. Once there, click on **"Fraud, Waste and Abuse Training."**

Once you have reviewed the training materials, **please complete the online attestation.** Once you hit the "submit" button, the attestation will go directly to Compliance Department and this will meet your annual FWA training requirement for 2010.

Alternatively, providers who have completed the training program through other health plans may send us proof of completion. We will accept attestations, sign-in sheets, or an email from you stating your completion of the FWA training requirement from XYZ health plan. Please send the documentation to Compliance Department at compliance@centralhealthplan.com and **add "FWA Training Requirement"** in the subject line of the email.

Please share this important information with your staff. We appreciate your efforts to help prevent, detect, and address any FWA activities from occurring!

Reporting Suspected Fraud, Waste, and Abuse

Health care fraud cost taxpayers billions of dollars each year. Therefore, it is in your best interest to prevent and detect FWA by reporting suspected individuals, entities, and activities. Participating providers should notify CHMP of any situations where provider billing fraud/abuse may have occurred, or where members have engaged in fraudulent or abusive activity. CHMP takes all allegations of fraud, waste, and abuse seriously and is committed to investigating each report in a timely manner.

If you suspect fraud, waste, or abuse, you can report it to CHMP through one of the following methods, **c/o Annie Kuo, Compliance Director:**

1. Telephone: The CHMP Compliance Hotline (626-388-2392) is a dedicated telephone line and voice mailbox that can be used twenty-four hours a day, from any location, for reporting concerns or violations.
2. Mail: 1540 Bridgegate Drive, Diamond Bar, CA 91765
3. E-mail: compliance@centralhealthplan.com

You have the right to have your concerns reported anonymously; however, please provide as much information as possible, to ensure the situation will be successfully reviewed and resolved. Thank you for helping us fight fraud, waste, and abuse! Together, we can make a difference!

Learning More About the CHMP's Corporate Compliance Program

A copy of the CHMP's Corporate Compliance Manual is incorporated into the Provider Manual. You can find additional information about CHMP's Code of Conduct, Anti-Fraud Plan, and Anti-Retaliation policy for reporting compliance violations in good faith. Please be on the lookout for an online version of the Provider Manual where you can access the Corporate Compliance Manual online.

We are committed to ensuring all participating providers understand CHMP's code of conduct and be familiar with CHMP's Corporate Compliance Program. Should you have any questions or need additional information relating to any aspect of CHMP's Corporate Compliance Program, please do not hesitate to contact CHMP's Compliance Director, Annie Kuo, at 626-388-2390 ext 2830 or email her at compliance@centralhealthplan.com.

We look forward to hearing from you and thank you for helping us maintain compliance with applicable federal and state healthcare laws!

HCC Risk Adjustment

Currently, the success and failure of medical health plans under the existing Center of Medicaid and Medicare services(CMS) HCC Risk Adjustment model has drawn physicians to focus in improving their documentation in their respective face to face visit with their individual patients.

HCC Risk Adjustment Model groups all known medical diagnosis into seventy HCCs. These HCCs are what CMS base their payment on and is expressed as a RISK Score. Whereby a higher HCC score would equal higher payment and no diagnosis equals to a no score, and a no score would equal a lower payment.

The following guidelines ensure providers and physicians into improving their HCC Risk Score:

1. **"Document"** - If a condition or diagnosis is not documented in a patient's progress note, therefore for CMS the diagnosis does not exist.
2. Avoid the following language - **"History of"** (means the condition is already cured.)
   - The same goes for "Probable", "Rule Out", "Working Diagnosis", and "Suspected".
3. Always remember to **sign** and **date** each face to face visit.
4. Submit all diagnosis codes at least **once a year** to ensure continuous reimbursement from CMS.
5. Physicians should **review all sources of information** from Laboratory results, Radiology reports, Pathology findings and consultation reports and make a habit of transferring the diagnosis in the patients next face to face visit.
6. Learn to **love modifiers.** The word **Chronic, secondary to,** and **related to** are modifiers that connect two existing conditions which would commonly be submitted separately.

Central Health Medicare Plan appreciates all of your efforts in ensuring accurate coding and documentation in medical progress notes. To learn more about CMS HCC Risk Adjustment Model, please contact Fermin Arceo MD at fdarceo@centralhealthplan.com or at (626)388-2390 ext. 3831.

Pharmacy Information & Formulary Changes

DRUGS TO BE AVOIDED IN THE ELDERLY MEMBERS

CHMP has implemented a quality improvement program to evaluate the medication profiles of our senior members over the age of 65 who are taking at least one potentially harmful medication based on published literature and Healthcare Effectiveness Data and Information Set (HEDIS) specifications.

Primary care physicians (PCPs) and prescribers were faxed program materials including a letter informing them that a CHMP patient under his/her care is receiving a medication considered to be potentially harmful and a reference table that includes reasons to avoid targeted medications and formulary alternatives.

FORMULARY CHANGES

Effective January 1, 2011, CHMP will have a six-tier formulary.

DRUG TIER	NETWORK PHARMACY* (30-DAY SUPPLY)
Tier 1: Preferred Generics	$0
Tier 2: Non-Preferred Generics	$5
Tier 3: Brands	$10
Tier 4: Preferred Brands	$25
Tier 5: Non- Preferred Brands	$50
Tier 6: Specialty Drug	33%

*For Central Health Medicare Plan members

The following is a list of CHMP commonly prescribed formulary brand medications and recommended formulary alternatives:

BRAND-NAME DRUG	FORMULARY STATUS	FORMULARY ALTERNATIVE(S) TO CONSIDER
Aricept	NF**	Namenda
Avodart	Tier 4	Finasteride/Tamsulosin HCL
Benicar	Tier 5	Losartan
Boniva	Tier 5	Alendronate
Celebrex	Tier 4 (ST)***	Meloxicam/Naproxen/Nabumetone/Diclofenac/Etodolac
Crestor	Tier 4 (ST)	Lovastatin/Simvastatin/Pravastatin
Detrol/Detrol LA	Tier 4 (ST)	Oxybutynin
Diovan	Tier 5 (ST)	Losartan (Cozaar)
Diovan HCT	Tier 5 (ST)	Losartan + HCTZ (Hyzaar)
Lidoderm	Tier 5	EMLA 2.5%/Xylocaine 2%
Lipitor	Tier 4 (ST)	Lovastatin/Simvastatin/Pravastatin
Lyrica	Tier 4	Gabapentin
Nexium	Tier 5 (ST)	Omeprazole/Lansoprazole/Pantoprazole

**NF indicates non-formulary ***ST indicates Step Therapy

ADDITIONAL INFORMATION

If you have any questions or concerns regarding any of these topics, please contact our Pharmacy Department at (626) 388-2390, option 3, then option 4.