CENTRAL HEALTH MEDICARE PLAN

A PROVIDER NEWSLETTER PUBLISHED BY CENTRAL HEALTH MEDICARE PLAN

2011 ISSUE

CENTRAL HEALTH E - NEWS

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Medicare Star Ratings "Star War Program"

The Center for Medicare and Medicaid Services (CMS) rates the quality of Medicare Advantage plans on a one to five-star scale with five stars representing the highest quality. The Medicare star ratings are published annually around the open enrollment period, which will be from October 15-December 7, 2011 for 2012 benefits. The summary score provides an overall measure of a plan's quality. We are endeavoring to attain a 5 Star rating.

The five-star quality scores for Medicare Advantage plans are derived from four sources:

- CMS administrative data on plan quality and member satisfaction
- the Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- the Healthcare Effectiveness Data and Information Set (HEDIS)
- the Health Outcomes Survey (HOS)

Starting in 2012, the MA Star Ratings are not only used to help beneficiaries differentiate among MA plans but CMS uses its Star Ratings to make quality bonus payments to higher-rated plans. Plans with four or more stars will receive bonuses along with higher rebates. Plans with fewer than three stars for the past three years will be flagged as low-quality plan on the CMS website.

The care that physicians provide to CHMP members has a great impact on our quality scores. CMS' star ratings are made in areas of Part C and D such as:

- Health Plan Responsiveness and Care
- Managing Chronic Conditions
- Staying Healthy
- Member Complaints
- Member Experience

We are increasing our outreach to members, reminding them to schedule and attend their annual preventive health exam, to obtain recommended tests and treatments for managing chronic conditions, and to take

medications as directed by their healthcare providers. To assist our members, we have provided our members with the “Passport to a Healthy You 2011” pocket guide which lists all Medicare recommended preventive measures for healthy seniors, and seniors with chronic conditions and with Diabetes that they can bring with them to their doctors’ visit.

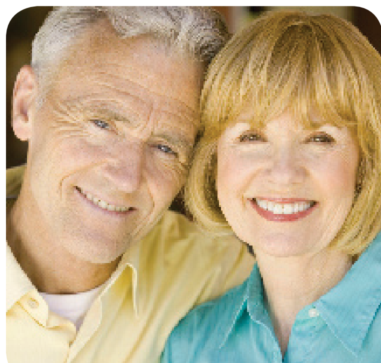
We have provided the “Star War 2011 – PCP Incentive Program (PIP)” handbook to all of our PCPs, in May this year. Upon fulfilling the requirements described in this booklet, CHMP will reward PCPs for promoting our quality improvement initiatives. We have also distributed a memo listing the updates to the PIP handbook in August, which include the calculation of 2012 PCP star score methodology. Based on the 2011 Star measures, CHMP will post PCPs’ Star scores on our Website in February 2012 and distribute the scores to all CHMP members.

As your partner in providing quality of care to our senior members, CHMP looks forward to working with you on behalf of the members we serve. Together, we can outreach and encourage our members and your patients to access the care and services they need.

For additional information regarding the “Star War PIP,” please contact us at (626) 388-2390 ext 2221 or visit our web site at https://www.centralhealthplan.com/cpa.

Central Health 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 2012 Senior Choice Gold Award for “Excellence in Medicare Benefits Value” in Los Angeles County and Orange County. This is the second consecutive year, and the third time over the last five years, 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.

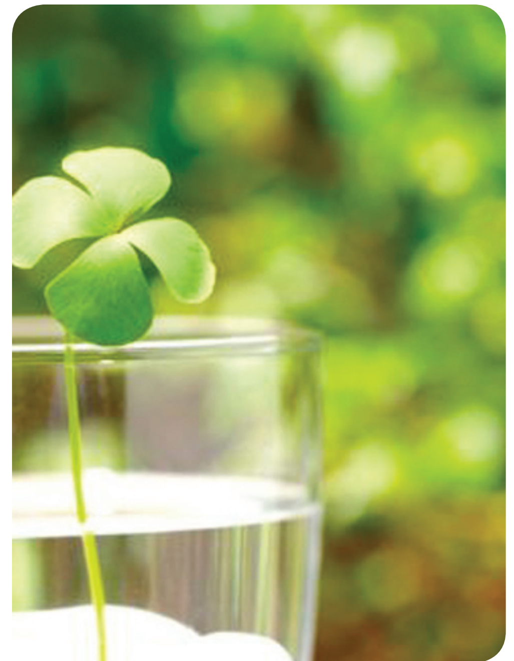


Risk Adjustment Myths and Facts

With all the changes in social structure and governmental policies, practicing medicine has become more difficult than ever. Besides identifying diseases and treating them, the administrative side of the practice is now equally important but it may look like a completely new world to physicians.

As you know, CMS calculates payment to health plans based on Risk Adjustment in accordance with the health conditions of your Medicare beneficiaries. The higher the Medicare beneficiaries' health risks score is, the higher the medical expenses and thus leads to higher CMS payment to the plans. To reflect the conditions, physicians must submit all the diagnoses with proper documentation to support their submission.

We would like to share some Myths and Facts with you:



Myth #1:
I reported CHF and COPD on a member two years ago so you should have the record.

Fact:
CMS recalculates and updates risk scores twice a year. CMS interprets the condition as "cured" if not reported at least once a year, even though they are chronic and are not likely to be completely cured.

Myth #2:
My patient has a long history of diabetes (diagnosed 30 years ago) and now it is well-controlled by medication. I document it as "Patient with history of diabetes…"

Fact:
It is correct to document "history of diabetes (diagnosed 30 years ago)" under HPI (History of Present Illness); however, CMS interprets "history of" as "no longer exist". If the condition is well controlled, under Assessment, document "DM-well controlled, continue current med" without the phrase "history of"

Myth #3:
My diabetic patient has CKD II so it is appropriate to submit ICD-9 250.40 (DM with Renal Manifestation)

Fact:
There are two parts: First is the documentation. If CKD II is a complication from DM, you must document and describe the two conditions using "due to", "secondary to, or "with".
Second is what codes to submit. In the case, you should submit both 250.40 (DM with Renal Manifestation) and 585.2 (CKD Stage II). The key is to submit both the underlying condition and the complication.

Myth #4:
I submitted every single diagnosis but I don't see any major increase on my patient's risk score.

Fact: Only 3000 out of 12000 ICD-9-CM codes have Risk Adjustment value. Out of the 3000, risk score is calculated on a hierarchical structure. Conditions belong to the same category will only be counted once instead of adding up (For example CHF, pulmonary HTN and myocarditis all belong to the same category therefore only one diagnosis will be counted towards risk score calculation instead of three)

Myth #5:
I have EMR so all conditions including chronic and acute are automatically captured and submitted.

Fact:
EMR provides you a comprehensive problem list but you need to ensure all the active chronic conditions be saved under "Assessment" instead of "Past Medical History". In addition, some billing programs may have a limit on the number of diagnosis for automatic claim generation. You want to pay attention to claims with six or more diagnoses to make sure they are all included on the claim.

Myth #6:
I receive a flat capitation from my medical group so Risk Score and Risk Adjustment have no impact on me.

Fact:
Yes for now but not for long. Health plans pay medical groups based on a percentage received from CMS on reported risk scores. If the medical group has a majority of low risk membership and continue to compensate providers at a high flat rate, the medical group will suffer financially.

Myth #7:
I submit all encounters within 30 days of the service rendered. Why am I not seeing any increase on my patient's risk score?

Fact:
CMS updates risk score and payment twice a year and during each update, CMS utilizes data from a specific range based on date of service. The updated risk scores you see in July 2011 actually resulted from submission of your services rendered in 2010. According to CMS processing structure, there is a 7-18 months lag between the date of service and the updated payment. See the table below:

Date of Service	Submission Deadline to CMS	Payment Period
CY 2010	03/04/2011	7/2011 to 12/2011
7/2010 to 6/2011	09/02/2011	1/2012 to 6/2012
7/2011 to 6/2012	03/02/2012	7/2012 to 12/2012
CY 2011	09/07/2012	1/2013 to 6/2013

Sounds complicated? Central Health Plan is here to help. Please call Risk Adjustment Department at 626-388-2390 x 3832 or email to stran@centralhealthplan.com for any questions on coding, training schedule, and record review.

Transferring Patients from One IPA to Another – How to Avoid CMS Disciplinary Action

This is a friendly reminder that Providers may not steer or attempt to steer their members from one IPA to another based on financial incentives. Patients trust health care professionals to provide them with complete information. If a patient wants to ask for your professional opinion on a health plan that will suit their needs, please be willing to provide complete information on all of the health plans and IPAs that you are contracted with. CMS prohibits Providers from marketing on behalf of their contracted IPA or health plans, which includes activities such as offering sales or appointment forms, or accepting enrollment applications on behalf of plans. Remember, Providers should remain neutral parties in assisting with enrollment decisions.

Haven't Completed Your 2011 Annual Compliance and HIPAA Training Yet? We will still accept Your Attestations!

All first-tier, downstream and related entities participating in CHMP's network are required by CMS to participate in Fraud, Waste & Abuse (FWA) training each year. The purpose of the training is to prevent, identify and report fraud, waste, and abuse.

If you have not yet received our fax blast and/or submitted an attestation for your 2011 mandatory training requirement, we will still accept your documentation until 2012 training is released through **any one** of the following easy options:

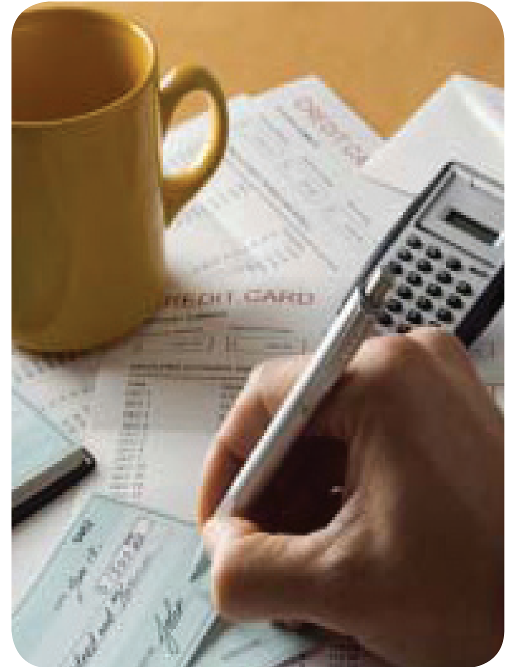
1. **Access Us.** Find the FWA Training materials at www.centralhealthplan.com and click on the "Provider" tab for "Fraud, Waste and Abuse Training." Once you have reviewed the training materials, please complete the online attestation, which will automatically be emailed to Compliance Department.

2. **Fax Us.** Review our handy brochure on FWA that you may have already received by fax! Reading the brochure and signing the accompanying attestation form will also satisfy the annual training requirement. Fax the attestation back to us at **(626) 388-2367**.

3. **Email Us**. If you have completed the training program through other health plans, you 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 another health plan. Please send your documentation to compliance@centralhealthplan.com and add "FWA Training Requirement" in the subject line of the email.

We only need one attestation from each organization. Please share this important information with your staff. We expect to release 2012 Annual Compliance and HIPAA Training in mid-2012.

The Way You Bill Medicare or Medicare HMOs May Get You in Trouble!



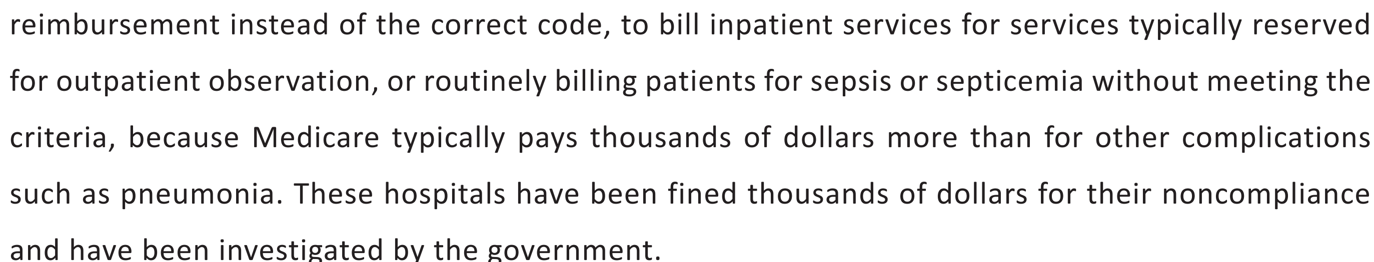
What is the False Claims Act (FCA)? The FCA is a law that prohibits any Providers from submitting false or fraudulent claims to Medicare and Medicare Advantage plans. Violations can range from $5,000 up to $10,000 plus a maximum of triple the damage for loss incurred by the government, exclusion from Medicare, and ***criminal imprisonment*** or additional fines.

With the Office of Inspector General (OIG) and the Department of Health & Human Services (HHS) teaming up to form the HEAT Strike Force, the government is keeping a much closer eye on Healthcare Fraud than ever before. CHMP will report to CMS/OIG any suspected billing fraud. Here are some tips and examples to help you avoid an FCA violation:

- **Billing for undocumented or medically unnecessary services:**
  Good documentation is vital. Before sending a claim, make sure that the records clearly indicate that the services took place and were medically necessary. The OIG recently found that 1 out of 5 claims for certain types of support surfaces used to prevent and treat bedsores were medically unnecessary, 9% of claims for power wheel chairs were medically unnecessary, and an additional 52% of the claims did not have sufficient documentation to indicate medical necessity.

- **Falsifying certificates of medical necessity:**
  Falsifying medical records is a ***felony*** and is punishable by fines, suspension or forfeiture of your license or time in federal prison.

- **Assigning incorrect codes to receive higher reimbursement, otherwise known as upcoding:**
  Assigning the correct diagnosis and CPT codes are important. Always consult the CPT code book if you have any questions. There has been a trend for certain hospitals to bill the codes with the highest



reimbursement instead of the correct code, to bill inpatient services for services typically reserved for outpatient observation, or routinely billing patients for sepsis or septicemia without meeting the criteria, because Medicare typically pays thousands of dollars more than for other complications such as pneumonia. These hospitals have been fined thousands of dollars for their noncompliance and have been investigated by the government.

- **Double billing for the same service:**
  Make sure to bill the service to the one plan that is active. If a patient has an arrangement for a secondary plan to help cover the cost of a service, bill the primary plan first and send a claim to the secondary payor with an Explanation of Benefits from the primary payor to clearly indicate that the service has been examined by a primary payor.

- **Unbundling or billing separately for services that should be billed together:**
  Modifier 25 has been recently targeted by the OIG under a special fraud alert for over-utilization. Modifier 25 is intended to report significant and separately identifiable Evaluation and Management services that were performed by the same physician on the same day of another procedure or service. When using Modifier 25, make sure that the patient either receives an evaluation that is "above and beyond" the normally expected evaluation prior to the procedure, is being reevaluated due to a change in condition, or presents a new and distinct problem that prompted the procedure. Documentation is not required at the time of filing a claim but should clearly indicate why a separate procedure or service was needed.

- **Failing to report and refund overpayments or credit balances:**
  If you overbill Medicare or CHMP, you must report and return the overpayment within 60 days from the time you either discover or should have reasonably discovered an overpayment. However, if you remain deliberately ignorant or file a claim to the government with a reckless disregard for the truth of the claim, you could also remain liable! Failure to report constitutes as a false claim.

If you suspect a violation of the FCA, you may make an anonymous report to Compliance at 626-388-2392, or email us at compliance@centralhealthplan.com

Formulary Changes

Effective January 1, 2012 CHMP will have a Five-tier formulary.

DRUG TIER	NETWORK PHARMACY* (30-DAY SUPPLY)
Tier 1: Preferred Generics	$0
Tier 2: Non-Preferred Generics	$5
Tier 3: Preferred Brands	$25
Tier 4: Non- Preferred Brands	$50
Tier 5: 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
Avodart	Tier 3 (ST)	finasteride/tamsulosin HCL
Benicar/Benicar HCT	Tier 4	losartan
Celebrex	Tier 3 (ST)	meloxicam/naproxen/nabumetone/diclofenac/etodolac
Crestor	Tier 3 (ST)	lovastatin/simvastatin/pravastatin
Diovan	Tier 3 (ST)	losartan (Cozaar)
Diovan HCT	Tier 3 (ST)	losartan + HCTZ (Hyzaar)
Lidoderm	Tier 4	EMLA 2.5%/xylocaine 2%
Lyrica	Tier 3	gabapentin
Nexium	Tier 4 (ST)	omeprazole/lansoprazole(ST)/pantoprazole(ST)

*ST indicates Step Therapy

Over-the-Counter Benefit

CHMP is pleased to continue to offer over-the-counter (OTC) benefit in 2012.

- Members of Central Health **Medicare Plan**: $8/month
- Members of Central Health **Medi-Medi Plan**: $25/month

The following OTC categories are covered under the OTC benefit

Allergy	Antihistamines	Cough Suppressant/ Expectorants	Hemorrhoidal
Analgesics/Antipyretics	Antacids and Acid Reducers	Dental/Denture Care	Motion Sickness
Antibiotics (topical)	Anti-itch Lotions and Creams	Eye Care	Sleeping Aids
Antidiarrheal/Laxatives	Cold, Flu, Decongestant and Sinus Remedies	First Aid/Medical Supplies	Topical Steroids

Medicare Star Ratings

As part of our commitment to quality care & PCP Incentive Program, CHMP conducts a medication review and alert providers when potential clinical concern(s) are identified, this may include the following:

1. Any members who are on any of the following persistent medications:
   - Angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)
   - Digoxin
   - Diuretics
   - Anticonvulsants

   ⇨ Please order a therapeutic monitoring test (basic metabolic panel or serum levels) for any members who received at least 180 days of medications shown above

2. Any members who have at least one prescription filled for a drug listed on the HEDIS list of High Risk Medications.

   ⇨ Please make necessary changes to the member's treatment plan. CHMP provides recommendations for safe drug alternatives

3. Any member with diabetes and hypertension

   ⇨ Please prescribe an ACE inhibitor or ARB medication

4. Any member who does not adhere to prescribed drug therapy for the specified drug classes in three therapeutic areas:
   - Oral diabetes medications (biguanides, sulfonylureas, thiazolidinediones, DPP-IV inhibitors)
   - Hypertension (ACEI, ARB)
   - Cholesterol (statins)

   ⇨ Please remind members to take medications as directed and emphasize the importance of compliance

5. Any member diagnosed with rheumatoid arthritis

   ⇨ Please prescribe a disease modifying anti-rheumatic drug (DMARD) or refer member to a rheumatologist

Please refer to the "Star War 2011- PCP Incentives & Quality Improvement Program" for details.

ADDITIONAL INFORMATION

CHMP periodically adds and removes drugs on its formulary. Please check the CHMP Website at **http://www.centralhealthplan.com/Benefits/Formulary.aspx** for formulary change notifications. For additional information, please contact CHMP Pharmacy Department at (626)388-2390, option 3, then option 4.

Utilization Management

Central Health Medicare Plan – UM Department continues to monitor, evaluate, and manage the quality and cost of health care services provided to our members. CHMP UM Committee has adopted decision making resources which include

- CMS Medicare Coverage Determination, Benefit, and Claims Manuals
- Evidence of Coverage (EOC) and internal guidelines.
- Milliman Care Guidelines
- Medical Review Criteria for Managed Care
- National Guideline Clearinghouse
- DSM IV Guidelines for Behavioral Health

In July 2011, CHMP has taken the delegation of concurrent Utilization Management of Inpatient admissions at acute hospitals. This was due to a growing concern regarding admissions that can only meet the medical criteria for Observation or a lower level of care. CPG's however, will continue to be delegated for all other Utilization Management services such as concurrent Utilization of LTACH, SNF, Home Health services, post discharge coordination with CHMP, and pre-certification of routine services.

All authorization decisions for benefit coverage and medical necessity are consistent with sound clinical principles and processes based on the review of medical records, discussions with the treating practitioners, and review of recognized criteria. CHMP does not specifically reward practitioners or other individuals for issuing denials of coverage or service. The Plan does not provide financial incentives for UM decision making for denials of coverage, service or decisions that result in underutilization.

CHMP UM staff are available during business hours to respond to inquiries about the utilization process and the authorization of care.

CHMP uses the Member satisfaction surveys, CAHPS Member satisfaction survey, and member complaints log to identify sources of dissatisfaction. Once analysis is performed, opportunities for improvement are identified, and interventions are implemented as indicated. CPG's are encouraged to advocate to our members the importance of completing the annual CAHPS surveys.

Quality Management

On an annual basis, CHMP engages in a Quality Improvement Project. This project, clinical or non-clinical, is expected to have a favorable effect in health outcomes and enrollee satisfaction. CHMP is currently focusing on all cause readmissions for 2012. This project is designed to identify all admissions, readmissions, root cause of the readmission, identifying gaps in care, and implementing interventions as indicated. Our Case Management Department works collaboratively with the Physician Group's Case Managers to ensure our beneficiary has the appropriate transitional care for continuity and access to care.

Health Risk Assessment

All new enrolled members with CHMP will receive a Health Risk Assessment questionnaire. This survey is focused on identifying the various needs of our members and provides identification of opportunities for continuity of care.

HEDIS

Our 2010 HEDIS results showed CHMP scored low on the Care for Older Adults. These measures include Advance Care Planning, Medication Review, Functional Status Assessment, and Pain Screening. In an effort to improve the effectiveness of care, CHMP encourages our Primary Care Providers to advocate the need for documenting your interventions in the mentioned areas.

Star War

In the 2nd Quarter of 2011, CHMP launched a Star War PCP incentive Program. This program is designed to comply with Medicare's Quality of Care requirements for senior beneficiaries. This directly provides financial incentives to the PCP's for their effort in improving the quality of care rendered to our members. For more information regarding the Star War PIP, just call our Quality Management Department at 1-866-314-2427.

Each QIP is developed to comply with CMS (Centers for Medicare and Medicaid Services) regulations.
For information on Quality Improvement Projects, just call our Quality Management Department at 1-866-314-2427.