CENTRAL HEALTH MEDICARE PLAN

May 2016 | V1

PROVIDER NEWSLETTER 2016

A Message from the Chief Medical Officer

Dear Provider,

Our plan began serving Medicare members in 2006, and this year we are proud to celebrate 10 years of service to our diverse community of Medicare patients in Los Angeles, San Bernardino, Orange, and Ventura Counties. We owe our success in large part to the support and dedication of our outstanding network of providers, and we want to thank you for working with us to provide excellent care to our members. Together with your help, here are some of the recent milestones we have achieved:

AN PANG CHIENG, M.D.
CHIEF MEDICAL OFFICER

32,000 members and growing!

On January 1 we were excited to welcome several thousand new members to Central Health, and our membership has recently surpassed 32,000. Our provider network now includes over 2,000 PCPs and over 4,000 specialists across 4 counties. We recently completed a partial service area expansion in San Bernardino County and we look forward to continued growth with your support.

New plan option for patients with Diabetes, CHF, and/or Cardiovascular Disease

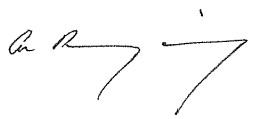
Last year, enrollment in Central Health Focus Plan was limited to patients with diabetes. Starting January 1, 2016, we are pleased to also welcome members with CHF or Cardiovascular Disease. Members with these chronic conditions quality for a special election period to join Focus Plan at any time throughout the year. To learn more about our model of care (MOC) for patients in this plan, please see page 9. If you have not done so already, we encourage you to complete our required annual MOC training.

2015 PCP Incentive Program

Every year, we offer a program for PCPs to earn incentives for completing STAR measures recommended by CMS. In 2015, PCPs were eligible to receive up to $367 per member and over 300 PCPs participated! We received excellent feedback from providers on the simplicity and convenience of our online registration and submission process, and we expect to release details for the 2016 program shortly. All PCPs in our network are eligible to participate.

As always, please feel free to contact us with any feedback or questions about Central Health. You will find a list of contacts on the last page of this newsletter.

Regards,



An Pang Chieng, M.D.
Chief Medical Officer


Health St

Central Health Wellness Centers Can Help Increase PCP Star Scores

Central Health Wellness Centers can help you complete CMS Star measures. If the Wellness Center has completed any of the measures listed in Central Health's 2016 PCP Incentive Program, with dates of service in 2016, you will receive the full incentive amounts for any completed measures. In 2015, the Wellness Centers helped PCPs earn an average of $100 per patient seen at the Wellness Centers.

The Wellness Centers are equipped to complete most of the Star measures required by CMS. If any measures require specialty referrals (e.g. mammogram), our staff at the Wellness Centers can submit authorizations on your behalf if your IPA has a letter of agreement with the Wellness Centers. IPAs that are interested in signing a letter of agreement with the Wellness Centers can contact Central Health at (626) 388-2359 (Monday to Friday, 9 AM to 5 PM) for more information.

The Wellness Centers will forward all reports and test results to your office. It is the PCP's responsibility to follow up with each patient to review the results. Central Health Wellness Centers are located at:

17595 Almahurst St., 101-1
City of Industry, CA 91748

806 S. Garfield Ave.,
Alhambra, CA 91801

The Wellness Centers do **not accept walk-ins**. If you are interested in referring your Central Health patients to the Wellness Centers, please have them call (626) 388-2359 to make an appointment (Monday to Friday, 9 AM to 5 PM).

If you are interested in having our Wellness Center staff provide these services to your Central Health patients at your office, please contact us at (626) 388-2359 for more information (Monday to Friday, 9 AM to 5 PM).

HEDIS
DOCUMENTATION TIPS

Healthcare Effectiveness Data and Information Set (HEDIS) measures are weighted most heavily in Star Ratings. Some HEDIS measures are rated through patient chart review. If they are not documented correctly, they are considered non-compliant regardless if the screening has been provided to the patient. The following are general rules for proper documentation in the progress notes for HEDIS measures:

General Rules: All progress notes should have:

- Patient identifiers (e.g., name, date of birth, etc.)
- Date of service (DOS)
- Provider's printed name, signature, and credential (Electronic notes must be signed electronically)
- If an encounter has multiple pages, the patient identifiers, DOS, and provider name, signature, and credential must be on every page unless there are page numbers to indicate they are for the same encounter

Adult BMI Assessment (ABA):

- Measure and document weight, height, and body mass index (BMI) at least once yearly

Controlling High Blood Pressure (CBP):

- Diagnosis of hypertension (HTN) should be documented in every visit for your HTN patients; BP should be measured and documented in every visit
- BP should be measured and documented in every visit
- If there are multiple BP measurements in one visit, use the lowest systolic and lowest diastolic BP to determine if the patient's BP reading is meeting the target threshold. (In other words, the lowest systolic BP and the lowest diastolic BP can come from different measurements if they are measured in the same visit.)
- Following are target thresholds:
  - < 140/90mmHg for HTN patients who are < 60 y/o
  - < 140/90mmHg for HTN patients who also have Diabetes (DM)
  - < 150/90mmHg for HTN patients who are ≥ 60 y/o and have no DM

Comprehensive Diabetes Care (CDC):

- Diagnosis of DM should be documented in every visit for your DM patients
- Document related complications that you identified (e.g. diabetic retinopathy, neuropathy, nephropathy, etc.)
- Include lab testing dates when documenting the HbA1C and urine microalbumin results on your progress note
- CMS recommends DM patients to be on ACEI/ARB and statins; document these medication names on your progress note if your DM patient is using them
- To document that your DM patient has received a retina exam performed by an eye specialist, you need to document all of the following: (1) Eye exam date, (2) Specialist type (optometrist or ophthalmologist), (3) Exam type (retinal or dilated), and (4) Result (normal or has retinopathy)

Care for Older Adults (COA) Advance Care Planning:

- Any one of following may satisfy this measure:
  - Having advance care plan in patient's chart (e.g., living will, power of attorney, physician orders for life sustaining treatment (POLST), or surrogate decision maker)
  - Document that you have discussed advance care planning on your progress note with DOS in 2016

Care for Older Adults (COA) Medication List and Review:

- The review must be performed by a prescribing provider
- If the patient is not taking any medication, it should be documented
- The medication list can be written within the progress note or on a separate sheet
- The reviewing provider needs to sign, write his/her credential, and the reviewing date on medication list

Care for Older Adults (COA) Functional Status Assessment:

- Documenting "functional status assessment has been performed" is **NOT** compliant to this measure
- Provider must specify the types of functional status assessment on their documentation. Any one of following is compliant:
  - Activities of Daily Living (ADL). Example: ADL all normal
  - Instrumental Activities of Daily Living (IADL) Example: IADL all normal except transportation
  - Usage of a standardized functional status assessment tool **AND** its result Example: Katz Index 6 out of 6

Care for Older Adults (COA) Pain Assessment:

- Document the location of pain *with a numeric scale* to rate the pain; documentation of chest pain alone does not meet criteria

Colorectal Cancer Screening (COL)

- If you don't have a specialist report or FOBT results but you know your patient has completed colon cancer screening within the proper timeframe, you must document the SPECIFIC TYPE of exam, approximate exam date, and the result. Only the following three exam types are acceptable:
  - Colonoscopy: at least one after 01/01/2007 Example: colonoscopy 2009 had polypectomy
  - Sigmoidoscopy: at least one after 01/01/2012 Example: sigmoidoscopy 2015, normal
  - Take-Home FOBT must be in 2016. In-Office FOBT is **NOT** acceptable. Document the FOBT type and number of samples tested if possible Example: gFOBT x 3 normal

Medication Reconciliation Post-Discharge (MRP)

- Must be done by clinicians within 30 days since hospital discharge
- If the patient has no discharge medication, it must be documented on progress note
- If the patient's discharge medications are the same as home medications prior the hospitalization, you need to document it: e.g., no changes in medications since discharge; same medications upon discharge
- If your patient has discharge medications, all of the following are needed to satisfy this measure:
  - Notation of hospital discharge
  - Document the name(s) of discharge medication(s)
  - Document your instructions regarding discharge medication(s) Example: continue/discontinue discharge medications

Standards for Accessibility of Providers

Accessibility is the timeliness within which a member can obtain available services. Central Health's standards are realistic for the community, and are prioritized according to the clinical urgency of the situation.

1. SPECIFIC TIME FRAMES FOR PRIMARY CARE AND SPECIALTY APPOINTMENTS

a. Routine appointments	7 days
b. Preventive care appointments	30 days
c. Urgent care appointments	Within 24 hours
d. Emergent care	Immediate
e. Specialist Consultation Non-urgent	Within 14 calendar days
f. Specialist Consultation Urgent	Within 24 hours
g. Office Waiting Time	Within 15 minutes of appointment

2. SPECIFIC TIME FRAMES FOR BEHAVIORAL HEALTH APPOINTMENTS

a. Routine office visit	Within 10 working days
b. Non-life threatening emergency care	Within 6 hours
c. Urgent care	Within 48 hours

3. SPECIFIC TIME FRAMES FOR DENTAL APPOINTMENTS

a. Urgent appointment within network	Within 72 hours of request
b. Non-urgent appointment within network	Within 36 business days
c. Preventive dental care	Within 40 business days

4. TELEPHONE ACCESS STANDARDS FOR PCP OFFICES

a. Average wait time on hold	30 seconds or less
b. Answering Service	24/7 including weekends & holidays

5. ACCESS TO TRIAGE/SCREENING SERVICES BY TELEPHONE 24HRS / 7 DAYS A WK.

a. Waiting Time to access Triage/Screening Services	Within 30 minutes
b. Waiting Time to Schedule Appointment	Within 30 minutes

6. AFTER HOURS & WEEKEND CARE

a. Primary care providers are expected to provide an after-hours answering service or telephone system which will allow members to contact the provider. If the provider is unavailable and the patient feels s/he has a serious acute medical condition, the answering service should inform patients to seek immediate care by calling 911 or going to the nearest emergency room. All phone calls to providers during evening, holiday and weekend hours should be answered by the designated service or message machine.

b. Physicians providing “on-call” coverage are expected to follow the same access and availability guidelines.

7. PROVIDER FACILITIES ARE EXPECTED TO PROVIDE ACCESS FOR DISABLED MEMBERS IN ACCORDANCE WITH THE AMERICAN DISABILITIES ACT (ADA)

PROVIDER IDENTITY THEFT

Provider identity theft can have a significant financial impact on providers, insurance companies, and the Medicare program, and can potentially harm a provider's professional reputation. The Centers for Medicare & Medicaid Services' (CMS) Center for Program Integrity (CPI) has posted new Provider Identity Theft videos on their CMS Outreach & Education MEDIC website. The video comes in the form of a three-part interview series with Dr. Shantanu Agrawal, the Director of CPI, who explains provider identity theft and its impact. Dr. Agrawal offers advice on how to recognize, report and prevent the fraudulent use of a provider's medical identification information and describes the roles that providers, insurance companies and CMS play to address this important issue.

In order to watch these videos, you must first sign up for the website in the following URL: http://medic-outreach.rainmakerssolutions.com/. Signing up for the website is free. Once you sign in using your profile, click on the "Professional Education" link near the top and scroll down to "Provider Identity Theft." Clicking on that box will show additional information and a "More" button. Clicking the "More" button will link you directly to the video.

SPECIAL NEEDS PLAN (SNP) UPDATES

As part of our provider network, Central Health invites you to participate in Model of Care (MOC) training to align our mutual goals for the benefit of our SNP members. This training is required by CMS annually. If you have already completed your 2016 training, thank you for your dedication.

If you have not completed your 2016 training, please go to http://www.centralhealthplan.com/cpa

⇨ Navigate to "Compliance Program" in the lefthand menu and select "Special Needs Plan"
⇨ Follow the instructions and click on the link to start the training
⇨ When you have completed the training, please complete the attestation form

Central Health will be providing updates to our SNP program bi-annually.
The following are the most recent updates:

- CHMP is proud to announce that we have stepped up our care coordination in our SNP team. We have re-structured and hired a brand new team of clinical personnel to better serve our SNP members. CHMP has also developed new software to facilitate the multi-faceted aspect of SNP care management. We aim to improve the HRA completion rate and timely completion of each individual care plan (ICP).
- Our SNP team is dedicated to reducing the 30 day readmission rate in our SNP population. Our goal rate is <15%. In the fourth quarter of 2015, we achieved a 13% readmission rate for Central Health Medi-Medi Plan (002) and 10% readmission rate for Central Health Focus Plan (006). The SNP team has introduced a transition of care program that includes post-discharge calls to the member from our inpatient case manager within 72hrs and 14-21 days after discharge. Afterwards, our SNP case managers are responsible for long term follow up.
- We also aim to improve diabetic control in our SNP population. Our goal is for 60% of our members to have HbA1c of <9.0. In 2015, 92% of our diabetic members in Central Health Medi-Medi Plan (002) and 72% of our diabetic members in Central Health Focus Plan (006) met this benchmark.

ATTENTION: FEBRUARY 1, 2017 IS THE DEADLINE TO ENSURE YOUR PATIENTS' PART D PRESCRIPTIONS ARE NOT DENIED BY EITHER: 1) ENROLLING IN MEDICARE OR 2) HAVING A VALID OPT-OUT AFFIDAVIT ON FILE!

To ensure your patients' Part D prescriptions will not be denied beginning February 1, 2017, you MUST either: 1) be enrolled in Medicare on an approved status, or 2) have a valid opt-out affidavit on file with Medicare.

This applies if you write prescriptions for covered Part D drugs for Medicare beneficiaries and are a physician, dentist, or other eligible health professional, which includes but is not limited to:

- Physician Assistant
- Nurse Practitioner
- Clinical Nurse Specialist
- Certified Registered Nurse Anesthetist
- Certified Nurse-Midwife
- Clinical Social Worker
- Clinical Psychologist
- Registered Dietitian
- Nutrition Professional
- Physical Or Occupational Therapist
- Qualified Speech-Language Pathologist
- Qualified Audiologist

Beginning February 1, 2017, CMS will enforce a requirement that plans may not cover drugs prescribed by providers who are either: 1) not enrolled in, or 2) validly opted out of Medicare. Therefore, in order for prescriptions to be coverable under Part D, prescribers of Part D drugs must:

- Be enrolled in Medicare in an approved status; or
- Have a valid opt-out affidavit on file

Prescribers who are permitted to prescribe by applicable law, but who are not eligible to enroll in Medicare, such as pharmacists, are exempted from this requirement. In California, pharmacists are able to prescribe and dispense various medications, including hormonal birth control (the pill, the patch, and the ring), smoking cessation meds, and standard

prescriptions for international travelers.

If you wish to check your enrollment status, visit this website: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Part-D-Prescriber-Enrollment-Enrollment-File-Instructions.html

CMS strongly encourages prescribers of Part D drugs to submit their Medicare enrollment applications or opt-out affidavits to their Medicare Administrative Contractors (MACs) **before August 1, 2016.**

Your IPA / medical group received a memo from our UM-DO Department listing specific providers that have not yet enrolled in or validly opted out of Medicare. We have requested that our IPAs / medical groups follow up with these providers to ensure their enrollment before August 1, 2016.

Please make sure to either submit your enrollment application or opt-out affidavit timely by following the instructions below. **This will prevent your patients' prescription claims from being denied by our plan beginning February 1, 2017.** Should you have any questions, please contact CHPC Compliance Department at (626) 388-2390 ext. 2885 or compliance@centralhealthplan.com.

1. TO ENROLL INTO MEDICARE:

You may submit your application through 1) the CMS Internet-based Provider Enrollment, Chain and Ownership System (PECOS), or 2) submit a paper (CMS-855) enrollment application to the MAC. For Southern California, the MAC is Noridian Healthcare Solutions (phone: 855-609-9960 or website: https://med.noridianmedicare.com/web/jeb).

- The **Internet-based PECOS** may be accessed at: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/InternetbasedPECOS.html
  NOTE: If you already have an NPI and a NPPES user ID/password, you can use the same credentials to enroll in PECOS
- The **paper-based Medicare enrollment application** (CMS-855) may be downloaded at: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html
  You must mail your signed application/Certification Statement and supporting documents to Noridian Healthcare Solutions.

The following applications are available to you free of charge:

- The CMS-855O application is available to enroll in Medicare for the sole purpose of ordering, certifying, or prescribing coverable items or services (including Part D drugs) for your patients.
- The CMS-855I application should be used if you intend to bill Medicare or Medicare beneficiaries directly (billing a Medicare Advantage plan does not constitute billing Medicare directly).

Additional information about the enrollment process may be found at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Prescriber-Enrollment-Information.html

2. TO OPT-OUT OF MEDICARE:

You must mail a compreted opt-out affidavit to the MAC for Southern California, Noridian Healthcare Solutions. The affidavit form, further instructions, and contact information are available at: https://med.noridianmedicare.com/web/jeb/enrollment/opt-out
NOTE: Medicare payment cannot be made directly or indirectly for services furnished by an opt-out physician, except for certain emergency and urgent care services. Therefore, no payment may be made under Medicare or under a Medicare Advantage Plan for services furnished by an opt-out physician. (The drug is still Part D coverable.)

MEDICARE MEMBERS' RIGHTS

01 To be treated with dignity and respect at all times.

02 To be protected from discrimination.

03 To have their personal and health information kept private.

04 To get information in a way they understand from Medicare, health care providers, and contractors.

05 To get clear and simple information about Medicare to help them make health care decisions.

06 To have their questions about Medicare answered.

07 To have access to doctors, specialists, and hospitals.

08 To learn about their treatment choices in clear language that they can understand, and participate in treatment decisions.

09 To get health care services in a language they understand and in a culturally sensitive way.

010 To get emergency care when and where they need it.

011 To get a decision about health care payment, coverage of services, or prescription drug coverage.

012 To request a review (appeal) of certain decisions about health care payment, coverage of services, or prescription drug coverage.

013 To file complaints (sometimes called "grievances"), including complaints about the quality of their care.

CONTACT US

To contact Central Health Medicare Plan, please DIAL (626) 388-2390, then PRESS 1 for ENGLISH, PRESS 3 for PROVIDERS, and select one of the following Menu Options to reach the appropriate department.

To request member transportation for doctor's office visits, call Transportation Services at (855) 588-0881. For Allied Pacific IPA patients, please contact Allied Pacific IPA.

To learn more about our PCP Incentive Program, please contact the Star Department at (626) 388-2390 ext 2221 or e-email star@centralhealthplan.com.

CENTRAL HEALTH MEDICARE PLAN

1540 Bridgegate Drive, Diamond Bar, CA 91765
1-866-314-2427 www.centralhealthplan.com