Provider Bulletin

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On the Horizon

Back in January 1996, when the Alliance first started up by serving 25,000 Medi-Cal members in Santa Cruz County, the health plan had a budget of $50M, 55 staff and twelve board members. Today, almost fifteen years later, the Alliance serves over 200,000 members in three counties, with a budget of $540M, 240 staff and twenty one board members. My how things change…and will continue changing in the months to come.

Bridge to Reform

In 2011, many counties in California, including Santa Cruz, Monterey and Merced, will be exploring opportunities to expand coverage of medically indigent adults (MIAs) by leveraging new federal funding. Such programs are a "bridge to reform", since many of the MIAs will become Alliance Medi-Cal members in 2014, when the federal expansion of Medicaid will add about 45,000 new tri-county members to the health plan. Clearly, the capacity of Alliance providers to provide timely access and quality care to more residents of Central California is a major challenge on the horizon.

Care Based Incentives

The health plan serves our providers to the best of our ability, and operates incentive programs that reward access, quality and case management. Our physician community is strengthened by Alliance Medi-Cal payments that can be increased through incentive earnings. In April 2010, the Alliance paid $7.9M in incentive payments for services during the prior year, and most participating physicians netted Medicare equivalent payment or better.

Starting in 2011, the Alliance begins phasing in new Care Based Incentives (CBI) that measure specific medical practices, and align with the State's new funding requirements. CBI will reward specific best practices, maintain State funding support, and encourage member compliance and self care. A change from the past, CBI is an important step toward the future of local care provided in patient centered medical homes.

Alliance Case Management

As the Alliance implements CBI, we hear the challenge to better support case management of our members. With new economies of scale made possible by our expansion to serve Merced County, the Alliance is developing new case management support services focused on ED use, post-inpatient care, and our most medically complex cases. We plan to launch these programs in the fall of 2011, while keeping administrative costs at less than 6% of revenue.

The Alliance's mandate in a changing environment, and with an ongoing State budget deficit, is to make health care work better through local innovation. In partnership with you and 1,500 other providers in our region, I'm confident we can do that.

Thank you for your service to Alliance members, and best wishes for the coming New Year.

Alan McKay, Executive Director

Care Based Incentives

Following on from our lead article in this issue, the Alliance's new CBI program is for primary care providers. As you can see from the measures listed below, CBI is more comprehensive than our current incentive programs.

CBI measures include:

- **Relative Ranking Measures**
  - **Rate of Preventable Inpatient (IP) Admissions**
  - **Rate of Generic Prescriptions**
  - **Rate of use of Controller Medications for Asthma**
  - **Quality of Care Measures**
  - **Rate of Preventable Emergency Department (ED) Visits**
- **Target Measures**
  - **Rate of Primary Care Visits**
  - **Electronic Claims/Encounter Data Submittal**
- **Member Reassignment Threshold**
- **Fee for Service Measures**
  - **Pediatric Asthma Action Plans**
  - **Childhood Obesity Notification**
  - **Diabetes Services**
  - **Medication Management Agreements**
- **Increased prevalence of extended hours**

Over the last month, the Alliance has conducted a series of workshops to introduce CBI to our PCPs. Below are the most common questions raised during our CBI workshops.

Why does the Alliance need a new incentive program – aren't the current ones working?

The Quality Based Incentive program (QBI) and Utilization Management Incentive programs (UMI) have been very successful. These programs have increased the average payment to primary care physicians to 150% of Medi-Cal fee for service.

At the same time, the Alliance has led the State Medi-Cal managed care programs in preventive and chronic disease HEDIS indicators while saving the State significant dollars. In fact, due to this success, we wanted to expand our incentives to include measures that reflect a wider range of care. Also, the State is moving away from reimbursing plans for incentive programs that are characterized as "risk sharing" like UMI.

CBI captures important aspects of care in both QBI and UMI. CBI expands on QBI to include aspects of inpatient, ED and pharmacy use. These measures align with elements of care that determine success in UMI.

Finally, the State will also be monitoring the Alliance on how we are doing on some of the same measures that are in CBI. However, instead of an incentive, they will be using a decrease in payment to outlier plans. We want to align with you, our providers, to insure adequate funding in the future.

When does this all start – are the other incentives going away completely?

CBI will begin in 2011. Because this is the first year, we want to give you and the Alliance a year to transition to CBI. Therefore, QBI and UMI will continue and will account for 90% of the incentive dollars paid out. In 2012, CBI will be the only Alliance PCP incentive program.

I saw the list of "avoidable inpatient admissions". It looks like a lot of these are legitimate reasons for hospitalization. Why would I be "punished" for a patient being admitted for these diagnoses?

Studies have shown that effective primary care practices have a lower number of admissions for these conditions. It is important for the plan to share data with you regarding your patient's inpatient treatment as an incentive to improve. Please also remember, many of the measures are "relative" – not absolute. Your practice will be scored based on how your Alliance members do compared to your peer specialty group.

How does the patient centered medical home (PCMH) fit into CBI?

PCMH stresses many of the fundamentals of sound primary care. These include: care provided through a physician lead team, enhanced access, whole-person orientation, coordination of care across the delivery system and use of evidence-based medicine and clinical decision-support tools.

The CBI measures are outcomes that are supported by the PCMH. We feel strongly that practices that incorporate many of these precepts will also do well in CBI.

How will the Alliance help my practice succeed?

First, we found at the recent workshops that many practices are not aware of what we currently do to promote more appropriate care. We send your practice a list of patients who need certain preventive and chronic disease services. We also send reminders to your patients at the same time. We are going to do a better job of telling you what information we provide and how you can get it.

Also, CBI includes a number of new member incentives to encourage member's appropriate access to care. It is important that your practice knows about and leverages the Alliance's efforts.

In 2011, we will send you a quarterly practice profile regarding your CBI performance. Finally, we will be providing educational resources regarding PCMH strategies this coming year.

We are both apprehensive and excited about this next generation of the Alliance incentive program. Apprehensive because it is change and it will be a lot of work for all of us. We are excited because we are confident it will recognize and reward Alliances providers for the broader range of services that you provide.

Dr. Richard Helmer, Chief Medical Director

CBI Member Incentives

Alliance members in all programs will have the opportunity to participate in member incentives aimed to support members in engaging in healthy behaviors and to improve their health outcomes.

The 2011 Alliance member incentives are as follows:

Access Awareness

New members who complete and return a survey regarding access to care will be entered into a raffle for a $50 gift card. The incentive is intended to improve members' knowledge about appropriate access to care.

Asthma Action Plans (AAP)

Pediatric members who complete an AAP with their PCP will be entered into a monthly raffle for a $50 gift card. This incentive is intended to promote case management of asthma.

Body Mass Index (BMI) Reduction

Members ages 3-18 whose BMI is $\geq 90^{th}$ percentile and who are able to reduce their percentile by 10% by their next annual measurement will receive a $50 gift card. This incentive is intended to support members' efforts in lowering their BMI.

Diabetes Screenings

A $50 gift card will be awarded to members with diabetes as an incentive for them to obtain 4 specific diabetic screenings in a year.

ED Decision Improvement

Members who receive the "What to do when your child gets sick" book and complete and return the included survey will be entered into a raffle for a $50 gift card. This incentive is intended to reduce the number of preventable ED visits.

Kept Appointments

Members who keep appointments will be entered into a raffle for a $50 gift card. This incentive is intended to reduce the number of no-show appointments.

Returned Phone Calls

Members who return phone calls from Health Programs Coordinators and Chronic Disease Case Managers will be entered into a raffle for a $50 gift card. This incentive is intended to increase health education to our members.

Health Programs Update

Resources for Alliance Members Who Use Tobacco

As a medical professional, you know that smoking remains the number one cause of preventable death and disease in the United States. According to the CDC, for every person who dies from smoking, 20 more people suffer from at least one serious tobacco-related illness. The Alliance Tobacco Cessation Program supports your efforts to help patients become tobacco free.

1) We will send the member **easy to read materials** with information and tips on how to quit. Materials are available in English, Spanish, and Hmong.

2) We will help the member enroll in an approved **local smoking cessation class**, and we will cover the cost as a one-time benefit for members with Alliance as their primary insurance.

3) The **California Smokers' Helpline at 1-800-NO-BUTTS** provides free cessation counseling over the phone for any tobacco user within California. Counseling is available in English, Spanish, and four other languages, and via TTY/TDD for members with a hearing or speech impairment. A special counseling line is also available for people who use snuff or chew. (See right column for more information.)

The **Freedom From Smoking® Online** program is now available and free to the public. Anyone with online access can sign up at http://ffsonline.org/.

5) The Alliance covers smoking cessation aids, including the nicotine patch, nicotine gum, Zyban® and Chantix®. Members must have a prescription and show the pharmacist proof of enrollment in a smoking cessation program (this includes local classes, Helpline counseling, or the Freedom from Smoking online program).

How Physicians Can Help: Ask, Advise, Refer

"Asking and advising patients to quit is not just good patient care, but can actually double the chance a smoker will make a quit attempt," according to the California Smokers' Helpline. The *Ask, Advise, Refer* program helps physicians and mid-level practitioners help their patients quit using tobacco. The program encourages health care providers to ***ASK*** their patients if they use tobacco, ***ADVISE*** the ones who do to quit, and ***REFER*** them to the Helpline for free telephone counseling. See information below about free materials to assist you with referring patients.

California Smokers' Helpline
1-800-NO-BUTTS

According to the California Department of Public Health, **the success rate is double for smokers who receive a series of free counseling sessions from the California Smokers' Helpline** over the rate of smokers who try to quit on their own. In order to encourage your patients to call the Helpline, you can order free materials to display in your office and hand out to patients.

Order free brochures in multiple languages, Take Charge Gold Cards for the *Ask, Advise, Refer* program, or other patient materials by phone at **1-800-NO-BUTTS** (1-800-662-8887) or online at http://www.californiasmokershelpline.org/.

For more information, please call the free Alliance Health Education Line at (831) 430-5580.

Cultural Crossroads

Tips and Resources to Help You Communicate Better with Alliance Members

Tips for Talking with Senior Patients

Older patients often require a different approach to treating their illnesses, injuries, and conditions than younger patients. Communicating effectively with your older patients can call for a different approach as well.

The National Institute on Aging has published **"A Clinician's Handbook: Talking with your Older Patient."** The tips listed below were excerpted from this handbook and modified for space.

Improving communication with your older patients has practical benefits. It can:

- Help prevent medical errors
- Strengthen the patient-provider relationship
- Make the most of limited interaction time
- Lead to improved health outcomes

Use Proper Form of Address

Establish respect right away by using formal language. As one patient said, *"Don't call me Edna, and I won't call you Sonny."* You might ask your patient about preferred forms of address and how she or he would like to address you. Use Mr., Mrs., Ms., and so on. **Avoid using familiar terms, like "dear" and "hon," which tend to sound patronizing.** Be sure to talk to your staff about the importance of being respectful to your patients as well. Obviously, if a patient prefers to be called by his or her first name, honor their wishes.

Take a Few Moments to Establish Rapport

Introduce yourself clearly. Show from the start that you accept the patient and want to hear his or her concerns. **If you are a consultant in a hospital setting, remember to explain your role or refresh the patient's memory of it.** In the exam room, greet everyone and apologize for any delays. With new patients, try a few comments to promote rapport: *"Are you from this area?"* or *"Do you have family nearby?"* With established patients, friendly questions about their families or activities can relieve stress.

Avoid Interrupting

One study found that doctors, on average, interrupt patients within the first 18 seconds of the initial interview. **Once interrupted, a patient is less likely to reveal all of his or her concerns.** This means finding out what you need to know may require another visit or some follow-up phone calls.

Ensure Understanding

Conclude the visit by making sure the patient understands:

- What the main health issue is
- What he or she needs to do about it
- Why it is important to do it

One way to do this is the "teach-back method." **Ask patients to say what they understand from the visit.** Also, ask if there is anything that might keep the patient from carrying out the treatment plan.

For more tips for talking with older patients, go to the National Institute on Aging website and download the complete handbook at http://www.nia.nih.gov/HealthInformation/Publications/ClinicianHB/. For assistance, please contact Lynn Meier, Senior Health Educator, at lmeier@ccah-alliance.org or (831) 430-5570.

Member Update

Collecting and Billing Copayments

Members in the following Alliance lines of business have a copayment responsibility for some services.

Line of Business	Member Copayment	Copayment Maximum	Benefit Year
Healthy Families (HF)	$5 or $10 based on family income	$250/family	Oct. 1-Sep. 30
Healthy Kids (HK)	$5	$250/family	Jul. 1 – Jun. 30
Alliance Care IHSS	$5	$3,000/member	Jul. 1 – Jun. 30

The Alliance expects that you will be collecting the member's copayment at the time of service. The amount should be entered in box 29 of the CMS 1500 claim form. We will be deducting the applicable copayment amount from your claim even if you have not indicated on your claim that you collected it from the member.

We track members' copayments during the year. Once a member or family has reached the annual copayment maximum for that benefit year, we will stop deducting it from your claims. We will also issue the member a new ID card, reflecting no copayment responsibility. When the new benefit year begins, we send the member another ID card, indicating the appropriate copayment amount the member is responsible for. At that time, we will begin deducting the copayment amount from your claims again.

Since we can only track copayments as claims are processed, there may be situations where a member ends up paying more than his/her copayment maximum. In these cases, we will issue a refund to the member for the amount they overpaid.

Please note: Not all services have a copayment responsibility associated with them. There are no copayments for inpatient services, preventive health services, diagnostic services, durable medical equipment, perinatal services, family planning services, and home health care services, among others. If you have a question about whether or not a copayment is required for a specific type of service, please see our Provider Manual at www.ccah-alliance.org.

United Behavioral Health has changed their name to OptumHealth Behavioral Solutions of California

Mental health services for Alliance Healthy Families, Healthy Kids, Alliance Care IHSS and Alliance Care AIM members are provided through OptumHealth Behavioral Solutions of California, formally known as United Behavioral Health. Benefits and contact information has not changed. You can reach them at 1-800-808-5796 or via the web at www.liveandworkwell.com.

Alliance Policy Updates

Referrals and Authorized Referrals

The Alliance managed care model promotes the primary care provider (PCP) as the member's medical home and medical case manager. Alliance policy states that PCPs must refer their linked members to specialty care by submitting either a Referral Consultation Request (Referral) form or an Authorized Referral Request (AR) form (50-1). Determining which form to use will depend on what program the member is eligible under, whether the referring provider is contracted with the Alliance, and whether the referring provider is located within the Alliance service area, as indicated in the grid below.

A full copy of this grid can be found on the provider homepage, in the policy entitled "Authorization Process for Referrals to Out of Service Area Providers".

www.ccah-alliance.org/providerspdfs/Authorization.html

In the event of an urgent/emergent medical situation outside of the Alliance service area, the facility providing the service is required to contact the Alliance within one business day to confirm eligibility and service authorization.

Requirements for Referral of Members to Specialty Providers

MEDI-CAL	Contract Status	Criteria	In Directory?	Referral Only / Authorized Referral	Comments
In Service Area	Contracted	In Service Area/County Code.	Yes	Referral Only	State Defined Service Area: Merced, Monterey, Santa Cruz.
	Non-Contracted	In Service Area/County Code.	No		
Local Out of Service Area	Contracted	• Adjacent to Service Area • Existing referral pattern and claims payment • Resolves access issues	Yes	Referral Only	Must be contracted only.
Out of Service Area	Contracted	• Tertiary Care Providers • Resolves access issues. • Accept Alliance referral. • Will abide by contract.	No*	Authorized Referral	*Except for Contracted Tertiary Care Hospitals
	Non-Contracted	• Resolves access issues. • Accepts Alliance referrals.	No		

Other Lines of Business	Contract Status	Criteria	In Directory?	Referral Only / Authorized Referral	Comments
In Service Area	Contracted	In Service Area/County Code.	Yes	Referral Only	State Defined Service Area: Merced, Monterey, Santa Cruz.
	Non-Contracted	In Service Area/County Code.	No	**Authorized Referral**	
Local Out of Service Area	Contracted	• Adjacent to Service Area • Existing referral pattern and claims payment • Resolves access issues	Yes	Referral Only	Must be contracted only
Out of Service Area	Contracted	• Resolves access issues. • Accept Alliance referral. • Will abide by contract.	No*	Authorized Referral	*Except for Contracted Tertiary Care Hospitals
	Non-Contracted	• Resolves access issues. • Accepts Alliance referrals.	No	Authorized Referral	

All services requested will be reviewed for clinical appropriateness by an Alliance nurse, with final decisions made by the Chief Medical Officer/Associate Medical Director.

PCPs should promptly submit Referral and AR forms to the Alliance to ensure that claims submitted by the referring providers may be processed. Claims submitted without the required authorization will be denied.

Locating in-service area and/or in-network providers

The Alliance has an interactive provider directory that allows you to search by specialty. Only contracted, in-service area providers are listed in our directory, and therefore would only require a Referral Consultation Request form to refer members to these referring providers.

The Provider Directory is available at www.ccah-alliance.org under "Provider Home Page". You can search for Alliance providers online, view their contact information and also view who is accepting Alliance members at this time.

While we take great care to ensure the accuracy of every listing, the information is for reference only and is subject to change.

If you have any questions regarding Referrals or ARs, please contact your Provider Services Representative.

New Alliance Policy for Provision of General Anesthesia for Dental Procedures

The Alliance has revised its policy concerning the administration of general anesthesia (GA) for dental procedures to align current practices with guidelines developed by the American Academy of Pediatric Dentistry, the American Dental Association, and the American Academy of Pediatrics. The policy addresses both the indications for the use of GA and the procedure for gaining prior authorization for it.

Most patients undergoing dental procedures do not require GA, and as a rule the level of anesthesia for any patient should be the lowest level possible that will allow the dentist or oral surgeon to perform the needed procedure in a safe and humane manner. Under certain circumstances GA may be required:

- For patients, adult and pediatric, with certain physical, intellectual, behavioral or medically compromising conditions such as cognitive impairment or delay, cerebral palsy, epilepsy, or hyperactivity.
- Patients with dental restorative or surgical needs for whom local anesthesia is ineffective because of factors such as acute infection, anatomic variations, or allergy.
- The extremely uncooperative, fearful, anxious, or physically resistant child or adolescent with substantial dental needs.
- Patients who have sustained extreme orofacial or dental trauma
- Children under age 7 with extensive dental pathology who are uncooperative so that the needed work cannot be accomplished in a small number of visits to the dentist, or with severe medical complications or developmental disability.

In order to insure that GA is safe and appropriate and properly coordinated with the patient's overall medical care, the patient's primary care physician (PCP) will be asked to provide documentation that there are no medical contraindications to the use of GA and to verify the medical and/or behavioral criteria used for its justification This documentation can take one of several forms such as copies of the medical record for patients well known to the PCP, written or faxed attestation, or the use of a standardized form like the one attached to the policy and which has been provided to dental offices (additional copies available on request).

Authorization for the use of GA in dental procedures will thus require adequate documentation of the dental indications for anesthesia, the criteria that require that GA be used, and the documentation from the PCP that GA would be both safe and necessary.

While we acknowledge that these steps will mean some additional work, we believe it is critical to patient safety and quality of care, and therefore essential for our members and patients.

Dr. David Altman, Associate Medical Director

Upcoming Changes to Modifiers of Anesthesia Services

Effective for dates of service on or after March 1, 2011, the Department of Health Care Services will discontinue the use of current local modifiers ZA, ZB, ZC, ZD, ZE, ZF, ZG, ZH, ZI, ZJ, ZO, ZP, ZR, ZT, ZX and ZY used with anesthesia services.

These local modifiers will be replaced by HIPAA compliant HCPCS modifiers to comply with the provisions of HIPAA of 1996, Public Law 104-191, *Code of Federal Regulations*, Title 45, Section 162.1000.

Update to Anesthesia and Hysterectomy Procedures

Hysterectomy Consent Form Clarification for Anesthesiologists:

Anesthesiologists billing for the anesthesia time associated with a hysterectomy must provide a copy of the hysterectomy consent form, regardless of the CPT-4 procedure code billed.

Happy Holidays from Central California Alliance for Health

Central California Alliance for Health will be closed on the following dates:

12/23/10	**Christmas Eve Holiday (Observed)**
12/24/10	**Christmas Holiday (Observed)**
12/31/10	**New Year's Day Holiday (Observed)**

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Upcoming Meetings

Physician Advisory Group
Thursday, March 10, 2011 12:00 PM to 1:30 PM

In Santa Cruz County:
Board Room
Central California Alliance for Health
1600 Green Hills Road, Scotts Valley, California

In Monterey County:
Board Room
Central California Alliance for Health
339 Pajaro Street, Salinas, California

In Merced County:
Board Room
Central California Alliance for Health
530 West 16th Street, Merced, California

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