

PROVIDER

Published for
health care professionals by
Community Health Partnership, Inc.

Bulletin

September 2010

Vol. 5 No. 3

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Daily Living Services Continue to Transition

The transition of Community Health Partnership, Inc. (CHP) members from our internal Daily Living Assistant (DLA) Services to our provider network has gone very smoothly.

As of August 1, 2010, approximately 200 members have successfully transitioned with another 300-400 members still scheduled for transition.

CHP would like to sincerely thank all the providers who participated in the planning meetings held this past May and June. These meetings played a major role in the success of the member transitions.

A Job Fair held in June was well attended by our staff. Thanks again to those providers who participated in that event.

CHP is on target to have the majority of members transitioned to our provider network by the end of September. The response and readiness of our providers to accept our members, as well as a willingness to remain flexible as we work through the transition, has been well-appreciated by our members and the CHP Home Care Services Department.

COMPLIANCE

Health Information + Individual Identifying Information = PHI

Keeping Member Information Private

The Health Insurance Portability & Accountability Act (HIPAA) provides a framework for the establishment of a nationwide protection of patient confidentiality, security of electronic systems, and standards and requirements for electronic transmission of health information. HIPAA affects virtually everyone and every organization working in healthcare. Protected Health Information (PHI) means any individually identifiable health information about a person. PHI is protected under HIPAA and, therefore, cannot be disclosed by a Covered Entity without the agreement or authorization of that person, or as allowed by law. Information transmitted or maintained in any form such as verbal, written (paper) or electronic is protected.

The HIPAA Privacy Rule identifies several data elements which, when used alone or in combination, may lead to the identification of a specific person. These data elements are referred to as individually identifiable health information and relate to:

- Person's past, present and future health or condition
- Provision of health services to the person
- Past, present and future payment of health services to the person

It is easy to inadvertently disclose PHI, for example, by talking about something with an acquaintance that can easily identify the member's name

even if it is not mentioned. A conversation that shares even general information about a member's day is likely to reveal identifiers under HIPAA and quickly can move beyond an "honest mistake." Some examples of identifiers include:

- Names or geographic descriptions such as street, city, county
- Any dates related to an individual such as date of birth, admission, or discharge dates



- Medical record numbers, Social Security numbers, telephone numbers
- Health Plan affiliation, Health plan numbers
- Photographic images, web resources, social networking websites
- Unique characteristics, Health Care service descriptions
- Device and/or vehicle identifiers, serial numbers, license plate numbers

Take time to understand the types of situations where talking with an acquaintance can inadvertently disclose PHI, recognize identifiers that easily reveal PHI, and develop techniques

See **PHI and HIPAA** page 2

PHI and HIPAA

continued from page 1

to steer the conversation away from PHI and safeguard information. Some examples of situations safeguarding PHI include:

- You're walking through the grocery store one day and see a member/client. What should you do?
Answer: Let the client approach you first. It's all right to say hello, but don't ask how they are doing or question health status. It's all right to listen if they offer information.
- You had a negative encounter with a member/client and really need to vent after work. What can you discuss?
Answer: Client confidentiality **MUST** be maintained at all times – at work, during non-work hours, and after your employment.

Preventing violations and/or a confidentiality breach can significantly reduce the risk of accidental or intentional harm and damages to the client. It is everyone's responsibility to learn about PHI, report a confidentiality breach, and continue to learn how to improve PHI practices.

Some examples of safeguarding PHI:

- Verify who the other party is when sharing PHI via telephone
- PHI should not be left on voice mail or answering machines
- Use only internal e-mail system, which has been secured, when sharing PHI
- Never include PHI in e-mail subject lines, headers, or the first few lines of the message
- When printing PHI, be physically present at the printer unless the printer is in a secure/compliant area.
- Secure papers so you don't drop them
- Make sure names are not visible
- Do not leave PHI unattended
- Papers with client information should be shredded instead of placing in the trash

QUALITY IMPROVEMENT

Provider Relations Enhancing Provider Credentialing Process

One of Community Health Partnership's (CHP) strategic goals for 2010 is to ensure our provider options offer quality care and service for our members. This goal can be accomplished by enhancing our provider data and credential verification processes through a number of tactics.

A key target vital to enhancing quality care and service for our members is to maintain and ensure timely verification and accuracy of provider data. CHP is currently undergoing efforts to improve the efficiency of obtaining and processing required provider data in an effort to enhance credentialing standards established by Center for Medicare and Medicaid Services (CMS) and Wisconsin Department of Health Services (DHS).

CHP provider network credentialing and recredentialing standards apply to all required licensed, registered, certified and/or any other participation requirements pertaining to the provider type or group. Some physician and health care professional initial credentialing and recredentialing activities that comply with 42 CFR §422.204 requirements include:

- Provider application and requested documentation is received directly from a provider
- Appropriate letters and inquiries are generated to verify provider credentials
- Primary and secondary source verification is conducted by CHP on provider's information
- Information is entered into CHP database
- All original documentation and verifications are compiled as a "clean file" and tracking of specific elements begins
- Annual verification cycles, including recredentialing cycle, occur

CHP's Provider Relations staff may be in contact with provider organizations over the next several months as we are extensively reviewing all provider data in the following areas:

- Change of status relating to address, licensure, business arrangements
- Expiration dates of licensure, insurance, certification privileges
- Quality of care, complaints, concerns, issues, critical events, malpractice claims, adverse patterns or trends, third party evaluation, reports, survey or publicly accessible comparisons (such as nursing home compare and home health compare) and customer satisfaction results.

CHP is committed to continuous development of a competitive provider network for our members by strengthening our relationship, teamwork, and partnership with providers. We also believe that good, quality providers remain committed to similar long-term goals and relationships.

CHP intends to share further information related to additional new or enhanced services as we continue to meet and exceed our strategic goal efforts. As always, we welcome any feedback, inquiries, and questions you may have.

Assisted Living Room & Board Claims Submission

Claims for room and board at assisted living facilities should only be submitted with a quantity of "1" since room and board is a monthly charge.

Any claim(s) submitted for assisted living room and board that is billed in excess of this quantity limit will be denied back to the provider for re-submission. Your assistance with this concern is much appreciated.

Please contact Security Administrative Services at 800-548-1224 if you have any questions.

MANAGED CARE

Resource Allocation Decision Method

The Resource Allocation Decision (RAD) method was developed by the Department of Health Services (DHS) and the Family Care Partnership Program sites to facilitate decision making processes.

In December 1998, a workgroup of DHS managers and staff developed preliminary guidelines about the circumstances in which a Family Care Managed Care Organization (MCO) could decline to provide a service requested by a member. This was necessary to clarify that consumer preference is not the only determinant of Family Care services, and to provide a methodology for MCOs to balance outcomes with cost. The workgroup developed a draft that has been revised considerably with input from the four Partnership sites. The result is a standardized decision-making process intended to be useful for Partnership sites and Family Care MCOs.

MCOs are required to either use the RAD method as their service authorization process or an alternative method that has been approved by DHS. To date, all MCOs are using the RAD method to authorize services which are intended to:

- Instill Family Care values and consumer outcomes into daily case management practices.
- Maximize appropriate resource allocation decisions.
- Assure cost-efficiency in all resource expenditures, large and small.
- Assure consistency across sites, interdisciplinary teams, and time. This ensures fairness or equity (i.e., like cases are treated alike).
- Facilitate team meetings with steps and questions to guide teams. This increases team efficiency and reduces stress (by providing a clear structure focusing on outcomes).
- Train MCO managers and staff.

- Educate consumers and families. This demystifies MCO decisions, reduces power struggles, and misunderstandings.
- Preserve the flexibility and creativity critical to quality and program success. A standardized decision process can allow for greater flexibility than specific rules or criteria and is more outcomes-based.
- Provide guidelines for hearing officers in the State Fair Hearing Appeal process.

As a result of the RAD method, CHP Teams ask the following questions of member service requests:

- 1. What is the request?**
 - Why is it important to the member?
 - How will it help the member reach their goals?
 - What will happen if the request is not fulfilled?
- 2. What are some choices for the member to help fulfill their request/goals?**
 - What was tried?
 - What could be tried?
 - Are there other options than “ownership” or “purchase”?
 - Are other sources of help being considered?
- 3. Are there policies or rules to follow?**
 - Member works with team to identify policies or rules
- 4. What choice/decision works best in handling negotiations?**
- 5. What is the most cost-effective choice?**
- 6. Are the options reasonable by most standards?**

If the member disagrees, he/she is directed to follow the Grievance and Appeals process.

- Source: www.dhs.gov

QUALITY ASSURANCE

Consumer Assessment of Healthcare Providers and Systems

On an annual basis, feedback from CHP Members is collected and evaluated by Centers for Medicare and Medicaid (CMS) through the use of surveys.

One such survey is the Consumer Assessment of Healthcare Providers and Systems (CAHPS) program. This is a public-private initiative to develop standardized surveys of patients' experiences with ambulatory and facility-level care. Health care organizations, public and private purchasers, consumers, and researchers use CAHPS results to:

- Assess the patient-centeredness of care;
- Compare and report on performance;
- Improve quality of care.

The CAHPS Survey asks members to report on and evaluate their experiences with health care and is designed to capture consumer and patient perspectives on health care quality. The survey is conducted in the first half of a given calendar year and measures members' experiences with CHP over the previous six months. The survey sample is drawn from all individuals who have been members for at least six months.

See CAHPS Program page 4

PROVIDER NUTRITION TRAINING SESSIONS

River Falls Branch Office
Thursday, September 16, 2010
9:00 am - 12:00 pm

Eau Claire Main Office
Friday, September 17, 2010
1:00 pm - 4:00 pm

Certificate of Attendance =
 Three (3) hours for the day

Please register for the training session of your choice by calling the CHP Provider Relations Department at 715-838-7420.



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PHARMACY INFORMATION

Pharmacy Reminders & Updates

Transitions

When a member newly enrolls or when CHP's formulary changes, CHP members are provided notices informing them they will be transitioned from drug regimens or therapies that are not covered on the formulary to medications included on CHP's formulary. CHP's General Transition Notice is posted on the CHP website.

Formulary

CHP's Pharmacy and Therapeutics Committee, comprised of practicing physicians, nurse practitioners, and pharmacy providers from our community, is responsible for the development and maintenance of the CHP formulary.

The committee meets on a regular basis to review the formulary and to discuss CHP's Transition Policy and Procedure and Application for providing access to prescribed medications for CHP members.

To obtain the most up-to-date copy of CHP's formulary, providers are encouraged to view CHP's website and link to the Partnership Formulary section at: www.communityhealthpartnership.com.

Utilization Information

Did you know...

- CHP's generic dispensing rate increased from 78% to 81% from June 2009 to June 2010?
- the average CHP cost of a brand name drug was \$169.21 and the generic drug cost was \$17.07 during the 1st half of 2010?

CAHPS Program

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Another annual survey is the Healthcare Effectiveness Data and Information Set (HEDIS) which is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Recent areas measured include:

- Getting needed care
- Getting care quickly
- Doctors who communicate well
- Overall rating of Health Plan
- Overall rating of Health Care received

Medicare Advantage contract scores are reported on www.medicare.gov using a 1-to-5 star scale. The rankings appear as 5 stars – Excellent; 4 stars – Very Good; 3 stars – Good; 2 stars – Fair; 1 star – Poor. The algorithm for assigning stars combines information about the ranking of the contract case-mix adjusted mean score relative to other contracts, the reliability with which the mean is estimated in comparison to the distribution of means, and the statistical significance for the test of the difference of the contract mean from the national mean.

CHP is proud to currently hold a 4.5 Star Rating for the quality of care and services provided to its membership.

Claims Submission and Payment Change

Security Administrative Services (SAS), CHP's Third Party Administrator, will no longer allow claims to be dropped off at their offices for processing. Also, checks can no longer be picked up at their offices by providers.

As outlined in CHP's contract with our providers, claims should be submitted via mail or electronic submission in order for them to be processed according to company policy. When completed, checks for claims payments will be mailed to our providers.

CHP very much appreciates your cooperation with these changes in order to ensure your claims are processed timely and accurately. If you wish to inquire about electronic submission of claims, please contact SAS at 1-800-548-1224 to discuss this option.

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