Midwest October Newsletter

October 7, 2016

Changes Coming to Health Alliance Medicare

This year, we're offering Medicare Advantage point of service (POS) plans rather than preferred provider organization (PPO) plans. Since these members are already your patients, the transition for you will be easy.

Members on our 2016 PPO plans were sent letters telling them their PPO plan would be ending on December 31. If you get questions from these members, please tell them to call the number on the back of their ID cards and our customer service team can help walk them through the changes.

These members must enroll in an HMO or POS plan to keep their coverage with Health Alliance Medicare. We will host several meetings to help guide them through this transition, and our customer service and sales teams are also ready to help them make the transition.

Our POS plans are a good alternative for these members. A POS plan is a blend of an HMO and PPO. Like an HMO, members get the comfort of having an in-network primary care provider (PCP) to oversee their care, but like a PPO, they have the freedom to see out-of-network doctors.

We've always believed medical care is at its highest quality when it's guided by a PCP. Based on that and a national trend toward higher costs in PPOs, we are moving to plans that require PCPs. Both HMO and POS plans accomplish that.

2017 Preauthorization and Notification Changes – Effective January 1, 2017

- In addition to notifying Health Alliance for inpatient admission, facilities will need to begin notifying us of any observation stays.
- You must notify us within 24 hours, or the next business day if it's a holiday.

Online Claims Reprocessing Inquiries

We've moved claims reprocessing inquiries onto Your Health Alliance for providers.

You can track the status on inquiries easily on the site, and eliminate tedious and time-consuming paperwork. You can send inquiries for many reasons, including:

- Timely filing
- Coding
- No preauthorization
- Reimbursement questions

Register or log in to get started today.

IL Department of Healthcare and Family Services Announces Health Alliance Connect Medicaid Member Transition Plan

According to a plan developed by the Illinois Department of Healthcare and Family Services (HFS), Health Alliance Connect Medicaid coverage will end in 2 phases, beginning in northern Illinois on October 31 and in central Illinois on December 31. Members will be moved back to standard Medicaid fee-for-service until they choose a new plan or are assigned to a new plan. No one will lose Medicaid eligibility because of this change.

Family Health Plan and ACA Adults Transition Plan

- **Health Alliance coverage will end for members in these counties on October 31:**
  - Boone, Henry, Knox, McHenry, McLean, Mercer, Peoria, Rock Island, Stark, Tazewell, Winnebago
- **Health Alliance coverage will end for members in these counties on December 31:**
  - Champaign, Christian, DeWitt, Ford, Logan, Macon, Menard, Piatt, Sangamon, Vermilion
- FHP Disenrollment Transition Letter

ICP/SPD (Integrated Care Program/Seniors & Persons with Disabilities)

- **Health Alliance coverage will end for members in these counties on October 31:**
  - Knox, Peoria, Stark, Tazewell
- **Health Alliance coverage will end for members in these counties on December 31:**

    - Champaign, Christian, DeWitt, Ford, Henry, Logan, Macon, McLean, Menard, Mercer, Piatt, Rock Island, Sangamon, Vermilion
- SPD Disenrollment Transition Letter

Members will get a letter from Health Alliance Connect, followed by an enrollment packet from Illinois Client Enrollment Services with important information about all their health plan options and directions for enrolling. They will have 60 days to choose a new health plan and primary care provider (PCP). If they do not choose a health plan and PCP, HFS will choose for them. They can call their current PCP offices to find out what other plans they accept.

If members need healthcare services after their Health Alliance disenrollment date but before they're enrolled in a new health plan, they should bring their HFS medical card to doctor visits and the pharmacy. If they have questions, they should call us at 1-877-633-2526 (TTY 711).

You can learn more in our Health Alliance Connect Disenrollment FAQ, also available on Your Health Alliance's Forms & Resources section. If you have questions, call us at 1-800-851-3379, ext. 4668.

S2900 Billing Clarification – Robotic-Assisted Surgery

This code is not payable under our coverage. You can only bill for tracking purposes with no billed amount.

Health Alliance follows the Medicare coding standards for robotic-assisted surgery.

New Local Medicare Option Coming Soon

Reid Health and Health Alliance Medicare teamed up as Reid Health Alliance Medicare to bring local Medicare Advantage options to the community.

For 2017, we will offer plans in Fayette, Randolph, and Union counties in Indiana and Darke and Preble counties in Ohio. Members will also be able to see providers in Wayne County.

Health Alliance Medicare started in Illinois and has served members in the Midwest for more than 30 years. We will begin selling 2017 plans on October 15 and will have a local office at 600 E. Main St., Richmond, in the same building with Reid Patient Financial Services and across the street from Elder-Beerman.

Meet with a Coding Specialist

The Risk Adjustment coding consultants are making their rounds to high-volume participating provider offices sharing member-specific examples of coding and quality measure needs. A member of the team is happy to meet with you to discuss any coding or quality questions you may have, or to provide member-specific examples from your panel of members. If interested, contact us at CodingCounts@healthalliance.org.

BMI Requirements

HEDIS® requires a biannual calculation of body mass index (BMI). BMI is calculated by dividing a person's weight in kilograms by the square of height in meters. By current standards for adults, if the BMI is:

- Less than 18.5, it falls within the underweight range
- 18.5 to 24.9, it falls within the healthy weight range
- 25.0 to 29.9, it falls within the overweight range
- 30.0 or higher, it falls within the obese range

Make sure you're meeting this requirement by getting a height and weight from patients at least once a year.

In some cases, such as those with a high muscle mass, more than a BMI may be required to accurately diagnose obesity. Waist circumference is one measure that could help in these situations.

Importance of the Health Outcome Survey

The Star Rating system from Centers for Medicare and Medicaid Services (CMS) gives consumers the opportunity to compare Medicare Advantage plans each fall during the Annual Enrollment Period. The Health Outcome Survey (HOS) is an important part of that rating system.

Each spring, CMS mails the survey to a sampling of members from each Medicare Advantage contract. It asks the member questions to evaluate their physical and mental health, plus their day-to-day activities. If a member responds to a baseline survey, they will be surveyed again in 2 years to evaluate their health status over that time period.

Many of the questions in the survey can be addressed during yearly physicals. For example, the survey asks, "In the past 6 months, have you experienced leaking of urine?" If the member answers yes, they're asked "Have you ever talked with a doctor, nurse, or other health care provider about leaking urine?"

The survey also asks about treatment, "There are many ways to control or manage the leaking of urine, including bladder training exercises, medication, and surgery. Have you ever talked with a doctor, nurse, or other healthcare provider about any of these approaches?"

Other questions in the survey focus on activity level, fall risk assessment, and monitoring for depression at office visits. The HOS survey is an opportunity to evaluate how our members view their current health status, and if they address those concerns with their health care provider.

Please keep these questions in mind during annual visits with Medicare members.

ACA Coverage of Tobacco Cessation

In a medical record review, we've noted that in discussions of tobacco cessation, members have told providers that they couldn't afford the medications.

The Affordable Care Act (ACA) requires health insurers to cover FDA-approved tobacco cessation products for 90 days per quit attempt (for up to 2 quit attempts per year), without cost to the member. Prescriptions are required for this coverage.

We not only cover OTC Nicotine patches, gum, lozenges (with a prescription), but also Bupropion and Chantix. Free counseling over the phone without enrollment is also offered to better prepare our members for success. Many members might not be aware of this coverage to take advantage of the opportunity to quit tobacco use.

If you have questions about this, contact Penny Shaw RRT, Quality Improvement Coordinator, at 1-800-851-3379, ext. 3409, or email Penny.Shaw@healthalliance.org.

Updated 2015 Beers Criteria for Potentially Inappropriate Medication Use in Older Adults

Last year, the American Geriatrics society updated the Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. Use the guideline for detailed changes, but here is a brief overview of changes:

- Desmopressin – Avoid for treatment of nocturia and nocturnal polyuria.
- Proton-Pump Inhibitors – Avoid for more than 8 weeks duration, unless for high-risk patients, erosive esophagitis, Barrett's esophagitis, pathologic hyper secretory condition, or demonstrated need for maintenance treatment.
- Eszopiclone and Zaleplon – Added to the list of drugs to avoid in dementia or cognitive impairment.
- Opioids – Added to list of drugs to avoid in patients with a history of falls.

- Nitrofurantoin – Removed recommendation to avoid in CrCl<60 mL/min. The new recommendation is to avoid in individuals with CrCl<30 mL/min, and to continue to avoid long-term use due to potential pulmonary toxicity.
- Amiodarone – Avoid as first line unless the patient has heart failure or significant left ventricular hypertrophy.
- Dronadarone – Avoid in permanent atrial fibrillation or with severe or recently decompensated heart failure.
- Digoxin – Avoid as first line in atrial fibrillation and heart failure. Avoid doses greater than 0.125 mg/day.
- Non-Benzodiazepine Hypnotics – Changed from avoid use over 90 days to avoid use regardless of duration.
- Meperidine – Avoid use, especially in those with chronic kidney disease.
- Antipsychotics – Added to drugs to avoid in delirium. Antipsychotics should be avoided for patients with dementia if non-pharmacologic options have failed or are not possible.
- Indomethacin and Ketorolac – Indomethacin is more likely than other NSAIDs to have adverse CNS effects. Of all the NSAIDs, indomethacin has the most adverse effects, such as increased risk of gastrointestinal bleeding, peptic ulcer disease, and acute kidney injury in older adults.

Please keep these guidelines in mind when prescribing medication for seniors and when reviewing current medications they already take.

Contact Us

1-800-851-3379, option 3

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