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Inter Valley Health Plan
For health. Not for profit.

MEMBER SATISFACTION:

Getting Needed Care & Getting It Quickly.

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OFFICE PIZZA PARTY ON US!

See back for details.

MEMBER SATISFACTION: 2012 CAHPS SURVEY RESULTS

The Consumer Assessment of Health Programs and Systems (CAHPS) Survey is conducted annually by the Centers for Medicare & Medicaid Services (CMS) to assess the beneficiary experiences in Medicare Advantage Prescription Drug (MA-PD) Plans. The 2012 CAHPS survey, conducted between February and June, assessed the members' experiences with Inter Valley Health Plan over the previous six months. The survey sample was taken from all Inter Valley Health Plan members consecutively enrolled between July 2011 and January 2012.

A total of 41 Medicare Advantage plans in California participated in the 2012 CAHPS Survey. Inter Valley Health Plan's response rate is significantly higher at 73.0%, compared to an average of 54.7% among the other California Medicare Advantage Plans who participated. This places Inter Valley Health Plan's calculated means at much higher reliability levels.

New this year is the Care Coordination composite, which asks members how well the primary physicians and specialists work together to coordinate care. As in previous years, focus on access to medical and pharmacy services were central in the report. In 2012 however, the CMS retired the flu shot question, in favor of a more effective method to collect that data through encounters and claims.

The survey results, released in October, highlight many of Inter Valley Health Plan's strengths. They revealed high customer satisfaction ratings in the Plan's member services, the Part D drug benefit as well as member satisfaction with primary physicians, specialists and quality of care. CAHPS questions account for 20% of the total star ratings measures.

This year however, the Plan observed marked decreases in performances in member satisfaction with getting needed care and getting care quickly. Listed on page 3 are the composite ratings compared to last year's outcomes. Also listed are the star ratings that correspond to each composite score.

Some of the observations made were that the ratings lowered because member perception of "ease of getting referrals to specialists" was much more difficult this year. This could be attributed to a few factors: some members may just have unreasonably high expectations regarding how quickly they should be able to see specialists. In some cases, it was the time

2012 CAHPS SURVEY RESULTS

REPORTING COMPOSITE OR ITEM	2011	2012
Member Experience with Health Plan		
Getting Needed Care	85% 4★	82% 2★
Getting Appointments and Care Quickly	75% 4★	73% 2★
Overall Rating of Health Care Quality	85% 4★	87% 4★
Overall Rating of Health Plan	90% 5★	90% 5★
Customer Service	91% 5★	92% 5★
Care Coordination		82% 2★
Vaccine		
Flu Vaccination	68% 3★	70% 3★
Member Experience with Drug Plan		
Getting Needed Prescription Drugs	93% 5★	92% 4★
Getting Information from Plan About Prescription Drugs	87% 5★	89% 5★
Overall Rating of Prescription Drug Plan	88% 5★	88% 5★

it took for the referral to be submitted for approval that was the factor.

The interesting thing about the CAHPS Survey is that most of the 78 questions asked in the survey are subjective and based on individual perception. Additionally, the survey, although reported for each health plan, is asked of members who are seen by the same doctors in the community.

So why do health plans perform differently, if the services are rendered by the same doctors?

Well, perception plays a significant role; but the truth is that members indeed rate satisfaction consistently, since in most cases, as little as .03 points separate five star ratings from two stars. What this all means is that in some cases, survey outcomes ratings are decided by as little as two members who gave bad reviews of the plan.

Why is this important to know? Because it's imperative to understand that a two-star decline doesn't mean the quality of service and care has fallen drastically among providers in the community. It simply means that there were two or three individuals who may have been critical of the services they received. The Plan understands the challenges in today's medical practice. Inter Valley Health Plan stands by the good work performed by the providers in it's network. At the same token, the plan seeks your assistance in our efforts to achieve a Five-Star Rating by making extra sure that the care and services provided to Inter Valley Health Plan members are consistent and of high-quality.

BE THE ADVOCATE YOUR PATIENT NEEDS

When communication breaks down between primary and specialty care providers, it's the patient who suffers.

Some efforts to prevent breakdowns in the referral process include provision of feedback to providers, improved training, and regular meetings or joint consultations between providers. Additionally, referral guidelines may help improve the process by clarifying which conditions should be managed by the primary care provider (PCP) and which tests should be ordered before a referral, and by outlining the most effective ways for PCPs and specialists to communicate.

When you submit a referral for treatment you consider necessary and appropriate, keep a tracking log to ensure the referral is not inadvertently filed in the chart without the patient being notified. **You are your patients' advocate in the managed care system.**

Tips for Being a Better Patient Advocate

Explain: Make sure your patients are aware of both the efforts you have made to obtain authorization for a treatment or service and why you feel that treatment or service is needed. Explain the managed care system to your patients, including the Utilization Review (UR) process, how it operates, and what your role is.

Document: Accurately and clearly document your actions. Make sure all UR forms are centrally located and document when they are sent, the ultimate decision of the UR, and whether the patient has been notified.

Contact: Give patients a specific date to call you about a referral, if you have not already called them. Speak to them personally to avoid any confusion.

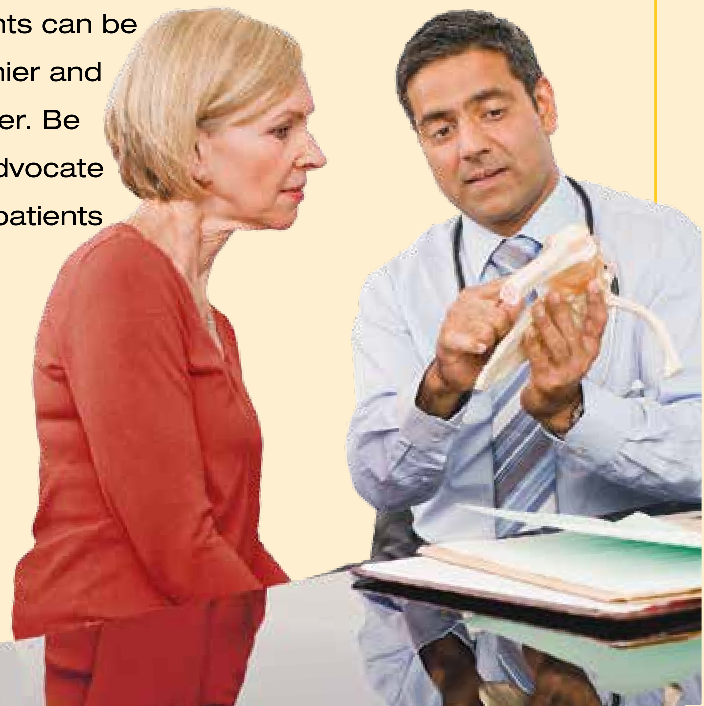
Poorly coordinated patient care can be expensive and can lead to setbacks such as:

Reduced continuity of care
Delayed diagnosis or treatment
Duplicate testing
Poly-pharmacy
Unnecessary hospitalization
Increased malpractice suits

Escalate: Treat any referrals in which failure to diagnose could have adverse results, such as breast masses, as emergencies. While the patient is in your office, generate referrals to obtain approval that day or the next day.

Advocate: Do everything possible to have a denial reversed if you believe that the decision could seriously jeopardize a patient's health. Appeal the referral and denial, if necessary, call the UR committee chairperson or Medical Director of the plan. Inform the patient of your efforts and document your referral attempts.

Remember that your patients are looking to you for care and guidance. Work with the Plan and with other providers to ensure that the referral process runs smoothly so that your patients can be healthier and happier. Be the advocate your patients need.



A CHANGE IS GONNA COME: THE ICD-10

The International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code set will be replaced by the International Classification of Diseases, 10th Edition, Procedure Coding System/Clinical Modification (ICD-10-PCS/CM) in 2014. This will affect diagnosis reporting with dates of service or discharge for inpatients that happen on and after October 1, 2014.

ICD-10-CM/PCS Transition: Planning and preparation checklist

The transition to ICD-10-CM and ICD-10-PCS (ICD-10) represents much more than just an increase in codes and field sizes. The scope and complexity of the transition are significant and should not be underestimated.

Codes and coded data are more widely used now than when the US transitioned to ICD-9-CM 30 years ago. The ICD-10 transition will have a pervasive impact throughout the entire healthcare industry and will be a significant undertaking for providers, payers, system vendors, and other stakeholders, requiring organization-wide planning and preparation.

Experience in other countries has shown that early preparation is the key to success. Organizations that start early can spread their resources across multiple years, rather than incurring a large budgetary investment at one time. Several of the preparation activities provide benefits to the organization before ICD-10 is implemented, such as clinical documentation improvement strategies and advancing the knowledge and skills of the coding staff.

ICD-9-CM Code	ICD-9 CM Description
25000	DMII without complications, not stated uncontrolled
25010	DMII with ketoacidosis, not stated uncontrolled
25040	DM with renal manifestations (Note: Use additonal code to identify the manifestation eg, CKD, nephropathy, etc)
25050	DM with ophthalmic manifestations (Note: Use additonal code to identify the manifestation eg, DM glaucoma, retinopathy etc)
25060	DM with neurological manifestations (Note: Use additional code to identify identify the manifestation eg, neuropathy, gastroparesis, etc)

ICD-10-CM Code	ICD-10-CM Description
E11.9	Type 2 DM without complications
E11.10	Type 2 CM with ketoacidosis without coma
E11.22	Type 2 DM with diabetic CKD (Note: Use additional code to idenify stage the of CKD (N18. 1-n18.6))
E11.36	Type 2 DM with diabetic cataract
E11.40	Type 2 DM with diabetic neuropathy, unspecified
E10 Code Ranges	Apply to Type 1 DM
E11 code Ranges	Apply to Type 2 DM

Many older patients have special concerns that can make communication difficult when they visit a physician's office. Communication between you, your staff and the patients you care for is vitally important to your patients' health and well-being. Older patients may also have physical limitations that aren't readily apparent, such as hearing and sight impairment. Arthritis of the hands, feet, and back is also common in older patients, which can make writing, walking, and bending difficult. The following tips could make your practice easier for your older patients to navigate.

- **Try mailing new patients any required paperwork** and directions to your office prior to their first visit. This allows older patients enough time to provide all the information you need and, if necessary, to have a friend or family member help them fill out the questionnaire. Asking your patient to bring in a list of concerns may be helpful as well.

- **Try to take care of all payment and paperwork** when they sign in at reception:
  - Ask for the co-payment and give them the receipt right away.
  - If the paperwork was not mailed, this is the time to hand it to them.
  - Place any paperwork on a clipboard, with the pen attached, so it does not fall to the ground.
  - Make it clear if they need to hand the paperwork back to you or if they should wait for the nurse to call them.

- **Do not assume** older patients know your procedures and where to go when called from the waiting room. Try using non-verbal communication to show them the way by gesturing with your hands. If possible, take vital signs in the same room where they will be seen so the patient does not have to stand up and walk to multiple locations, which may cause a rise in blood pressure and pulse.

- **Always speak face to face** with older patients in case they have hearing impairment. Do not speak to them while looking down at a chart, or at a computer screen. Even if a patient is nodding their head, it may not mean that they understand. When something is important, ask the patient to repeat it back to you to make sure that they heard and understood.

- **Provide written material** for an older patient to read at home or with family, especially one that might have memory problems. When talking to the patient, use terms that they will understand.

Your older patients are entitled to the same care and respect as anyone else. Treat them as you would like to be treated, and try to make their experience with you as trouble-free as possible.

BENEFIT ENHANCEMENTS FOR INTER VALLEY MEMBERS

Inter Valley Health Plan members will receive enhanced benefits for 2013. As the Medicare Advantage competition continues to be fierce in Southern California, Inter Valley made additional benefit enhancements to remain competitive in the marketplace and offer your patients a quality Plan for no additional premium.

This year Inter Valley is still rated overall as a 4-Star plan and we continue to receive a 5-Star rating for customer service. Your Inter Valley patients will receive high touch customer service and great benefits staying with Inter Valley.

Benefit Highlights for 2013:

$0 Copay for PCP

$0 Copay for Specialist

$0 Copay for Hospitalization

Gym, Vision, Chiropractic & Dental coverage for no additional Plan premium

If you have patients turning 65, encourage them to take a look at Inter Valley. They will be in good hands with us.

PHARMACY UPDATE

Inter Valley Health Plan's Pharmacy and Therapeutics Committee continually reviews all drugs for formulary inclusion or exclusion. Physicians can stay informed through this publication, Info-Link.

For more information about the drugs covered by Inter Valley Health Plan, please visit our website at www.ivhp.com/site/PrescriptionDrugSearch.Aspx or call Pharmacy Services, 7:30 am to 8 pm, 7 days a week, at 800-523-3142. TTY/TDD users should call 800-505-7150.

Service To Seniors Update:

Covered Drug Name	Alternate Drug Name	Tier Description	Utilization Limits
carisoprodol tab 350 mg (Oral)	SOMA	non-preferred generic	Removed PA
cyclobenzaprine tab 10 mg (Oral)	FLEXERIL	non-preferred generic	Removed PA
enoxaparin inj 30 mg/0.3 ml (Inj)	LOVENOX	non-preferred brand	PA,QL (8 per 30 days)
enoxaparin inj 40 mg/0.4 ml (Inj)	LOVENOX	non-preferred brand	PA,QL (11 per 30 days)
enoxaparin inj 60 mg/0.6 ml (Inj)	LOVENOX	non-preferred brand	PA,QL (17 per 30 days)
enoxaparin inj 80 mg/0.8 ml (Inj)	LOVENOX	non-preferred brand	PA,QL (22 per 30 days)
enoxaparin inj 100 mg/ml (Inj)	LOVENOX	specialty	PA,QL (28 per 30 days)
enoxaparin inj 120 mg/0.8 ml (Inj)	LOVENOX	specialty	PA,QL (22 per 30 days)
enoxaparin inj 150 mg/ml (Inj)	LOVENOX	specialty	PA,QL (28 per 30 days)
escitalopram tab 5,10,20 mg (Oral)	LEXAPRO	preferred generic	QL (30 per 30 days)
escitalopram sol 5 mg/5 ml (Oral)	LEXAPRO	non-preferred generic	QL (620 per 30 days)
methocarbamol tab 500, 750 mg (Oral)	ROBAXIN	non-preferred generic	Removed PA
modafinil tab 100, 200 mg (Oral)	PROVIGIL	non-preferred generic	QL (60 per 30 days)
NASONEX SPR 50 mcg/AC (NS)	MOMETASONE	non-preferred brand	QL (34 per 30 days)
pioglita/met 15-500 mg (Oral)	ACTOPLUS MET	preferred generic	QL (90 per 30 days)
pioglita/met 15-850 mg (Oral)	ACTOPLUS MET	preferred generic	QL (90 per 30 days)
SYMBICORT AER 80-4.5, 160-4.5 (Inh)	BUDESONIDE & FORMOTEROL	preferred brand	Addition
voriconazole tab 200 mg (Oral)	VFEND	non-preferred brand	PA
valsart/hctz tab 80-12.5 mg 160-12.5 mg 320-12.5 mg (Oral)	DIOVAN HCT	non-preferred generic	QL (30 per 30 days)
valsart/hctz tab 160-25 mg, 320-25 mg (Oral)	DIOVAN HCT	non-preferred generic	QL (30 per 30 days)
VICTOZA inj 18 mg/3 ml (Inj)	LIRAGLUTIDE	preferred brand	PA
Desert Preferred Choice Update:			
insulin syringes	insulin syringes	non-preferred generic	

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EDITOR'S NOTE:
We value your opinion. If you have any comments on this issue or have a topic suggestion for future issues, please contact Cyndie O'Brien at 909-623-6333 or cobrien@ivhp.com.

Inter Valley Health Plan
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Inter Valley Health Plan is a not-for-profit company and a Medicare Advantage Organization with a Medicare contract.

WIN A PIZZA PARTY ON US!

We are rewarding one lucky provider staff with a pizza party delivered to their office. For a chance to win pizza for your entire staff, simply fill in the blanks below correctly and mail or fax to Inter Valley Health Plan: Attention Pharmacy Dept. 300 S. Inter Valley Health Plan, 300 South Park Ave, PO Box 6002, Pomona CA 91769-6002, or fax it to 909-623-0753. Entries must be postmarked by January 31, 2013.

1. The composites related to ____________ _______________________ with getting ____________ _________ as well as member satisfaction with getting _________ ______________, suffered __________________ in performance, causing it's 2011 ________ -________ rating to go down to ________ -________ .

2. ...the plan seeks _________ _______________ in our efforts to ___________ a Five-Star Rating by making _________ _________ that the _________ and ______________ provided to IVHP members are consistent and of high-quality.