



**Gold Coast
Health Plan**SM
A Public Entity



Gold Coast Health Plan Provider Operations Bulletin

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SECTION 1: Low Income Health Program (LIHP) Transition

Pursuant to State and Federal laws the Medi-Cal program in California is expanding in January 2014. Most of the approximately 600,000 current Low Income Health Program (LIHP) enrollees (Statewide) will be transitioned to Medi-Cal at that time. This transition is occurring as part of the Affordable Care Act along with other changes to federal, state and county health care programs.

Most LIHP enrollees are in the Medicaid Expansion (MCE) part of LIHP. Effective January 1, 2014 these MCE enrollees will move to Medi-Cal managed care. Other LIHP enrollees will move to California's Health benefit Exchange, Covered California.

In Ventura County, the LIHP program is currently known as the ACE for Adults Program (ACE) and is administered through the Ventura County Health Care Agency (VCHCA). Approximately 9,000 LIHP individuals that qualify under MCE will transition to Gold Coast Health Plan (GCHP) on January 1, 2014. GCHP has been working closely with VCHCA to ensure a smooth transition. Currently, these members are assigned to a PCP and GCHP anticipates a 100% linkage to occur.

Member outreach and Notifications:

- DHCS notifications at 90 (10/04/13), 60 (11/01/13) and 30 (12/01/13) day intervals
- Member outreach (post cards and flyers) – GCHP and VCHCA
- GCHP Welcome Packets - January 7

LIHP members can be identified by their aid code – L1. Members may retain this aid code through 2015; however, the aid code may change if there is a change in their circumstances that triggers an aid code change.

Primary care provider (PCP) reimbursement for LIHP members will be on a fee-for-service (FFS) basis until an appropriate capitation rate can be developed. This is similar to how GCHP currently reimburses for administrative members. If it is determined that a change in rates is necessary, provider contracts may need to be amended. Specialist reimbursement will be at current FFS Medi-Cal Rates.

It is important to note that there are some variances between the current benefits LIHP members receive and the benefits they will receive under Medi-Cal. VCHCA provided for additional services that are not covered by Medi-Cal; GCHP will not offer these additional services. GCHP is working toward identifying the variances and will communicate our findings to members and providers as information becomes available.



SECTION 2: Behavioral Health Benefits

Effective January 1, 2014, all health plans are required to provide behavioral health benefits. Therefore, GCHP will provide this benefit as a covered Medi-Cal managed care plan. The new benefits provide for an expanded benefit for mild to moderate behavioral health conditions, as well as an expanded substance abuse benefit.

GCHP has entered into an agreement with Beacon, a managed behavioral health organization vendor (MBHO), to implement and administer behavioral health benefits to GCHP members. GCHP and Beacon are working together towards developing a network of providers.

Providers will be expected to utilize a depression rating tool to determine when to make a behavioral health referral. Additionally, providers will be expected to utilize substance use disorder trigger questions in the Staying Healthy Assessment (SHA or IHEBA) to determine which members will benefit from the SBIRT (screening, brief intervention, and referral for treatment).

DHCS is still clarifying the role of the PCP in implementing these new ACA benefits. GCHP will provide additional information as soon as it becomes available.

SECTION 3: How GCHP and CCS Work Together

As reported in the May 2013 edition of the GCHP Provider Operations Bulletin, California Children's Services (CCS) covers certain conditions that are physically disabling or require complex, interdisciplinary, medical, surgical, or rehabilitative treatment up to 21 years of age. Gold Coast Health Plan (GCHP) does not cover CCS eligible conditions. Conditions that are chronic, costly or catastrophic may fall under CCS eligibility. [Click here](#) to find a general outline of CCS eligible conditions.

CCS requires that a treating physician (the physician writing orders) be CCS-paneled. To become CCS paneled a physician must be Board Certified. A Primary Care Provider can become CCS paneled if he or she is Board Certified in Internal Medicine, Family Practice or Pediatrics.



CCS can accept orders only from a CCS paneled physician; however, anyone can make a referral to CCS. When you submit a Pre-Authorization Treatment Request Form to GCHP, a nurse reviews the request. If a possible CCS eligible condition is identified, the nurse will contact your office and advise that a Service Authorization Request (SAR) be sent by your office to CCS, if not already done. If your office staff is unfamiliar with this process, the GCHP nurse can provide assistance, however, GCHP does not submit SAR requests directly to CCS. SAR requests can be faxed to CCS at 805-658-4580 or e-faxed to CMS6584580@ventura.org. **Click here** to access the SAR link for new and established client referral forms.

You will always be sent a letter from GCHP advising that a “CCS deferral” has been made once a possible CCS condition has been identified and deferred to CCS.

Once CCS receives the request and necessary clinical documentation from you, a CCS nurse will make a medical eligibility determination. CCS cannot make a medical eligibility determination without supporting clinical documentation. The CCS medical eligibility process can take up to 5 days once all required documentation is received. If the child is medically eligible for CCS, residential and financial eligibility must also be determined. Parents should be encouraged to communicate with CCS as soon as they are contacted to avoid delays. GCHP nurses monitor the child’s needs during the CCS eligibility determination phase and communicate directly with the CCS nurses and case workers. Questions about CCS eligibility can be directed to CCS by calling 805-981-5281.

If CCS accepts the child as having a CCS eligible condition and approves the request, you will be notified by CCS and GCHP. If CCS denies the request because the child does not meet medical eligibility, you will be notified by CCS of that decision also. GCHP will then review for medical necessity.

GCHP and CCS work cooperatively for the benefit of the children and young adults of Ventura County. We encourage you to consider becoming a CCS paneled provider to aid in our mutual goal of providing excellent, expedient care to our children. **Click here** to learn more about becoming a CCS provider.

To answer your questions about CCS **click here** to access the DHCS website.



SECTION 4: November is American Diabetes Month®

GCHP is conducting a county-wide quality initiative project to improve the health plan's HEDIS scores for the Comprehensive Diabetes Care quality measure.

During the first week of November, staff from of the Quality Improvement Department will be visiting your clinics and distributing letters that will list the members assigned to your care in 2013 that have been diagnosed with diabetes. The letters will show which of the following 5 diabetic screenings/tests your members have completed or are still pending completion for the year 2013:

- HbA1c Testing
- HbA1c < 8
- Kidney Function Screening
- LDL Lipid Blood Test
- Annual Dilated Eye Exam
- Blood Pressure Test

The status of the tests/exams is based on our claims data up to July 2013. If the letter shows that your patient has not had one of the diabetic test/exams, but you have documentation showing your member has had the exam you do not have to schedule any additional appointments for the completed diabetic screenings/tests. We encourage all providers to schedule appointments for the incomplete tests/exams.

These letters are for your records and do not have to be returned to GCHP.

- You have an opportunity to ensure that your clinic scores very high on the Comprehensive Diabetic Care measure by contacting your members and scheduling an appointment before the end of the 2013 year. During the appointment please make sure documentation exists regarding services performed for each of these measures.

If you have any questions, please contact the Quality Improvement Department at (805) 981-6660 or (805) 981-6668.



SECTION 5: HEDIS Measures that did not meet the State's Required Minimum Performance Level

The following seven HEDIS quality measures fell below the national 25th percentile and below the Department of Healthcare Service's required minimum performance level (MPL). Providers can help improve the rates by utilizing the following coding, billing, and documentation tips.

1. **Weight Assessment & Counseling for Nutrition & Physical Activity**
2. **Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life**
3. **Children & Adolescent Access to Primary Care Practitioners**
4. **Cervical Cancer Screening**
5. **Avoidance of Antimitotic Treatment in Adults with Acute Bronchitis**
6. **Comprehensive Diabetes Care HbA1c Control < 8.0%**
7. **Comprehensive Diabetes Care Annual Retinal Eye Exam**

Coding & Billing Tips to Improve HEDIS rates

- Code and bill for all services performed.
- Submit claims AND encounter forms for all services performed.
- If it is not coded or billed and submitted on a claim or encounter form, the health plan has no documentation that the services were performed.

Documentation Tips for the HEDIS Measures that fell below the MPL (25th percentile)

Weight Assessment & Counseling for Nutrition & Physical Activity

Documentation in the medical record must include a note indicating the date of service and ALL three of the following assessments:

1. BMI percentile must include the member's height, weight and BMI percentile.
2. Counseling for nutrition must include documentation of **one** of the following:
 - Discussion of current nutritional behaviors
 - Checklist indicating nutrition was addressed
 - Counseling or referral for nutrition education
 - Member received educational materials on nutrition during the office visit
 - Anticipatory guidance for nutrition
 - Weight or obesity counseling



3. Counseling for physical activity must include documentation of one of the following:
 - Discussion of current physical activity behaviors (i.e., exercise routine, participation in sports)
 - Checklist indicating physical activity was addressed
 - Counseling or referral for physical activity
 - Member received educational materials on physical activity during the office visit
 - Anticipatory guidance for physical activity
 - Weight or obesity counseling

Well-Child Visits in the 3rd, 4th, 5th & 6th Years of Life

Documentation in the medical record must include a note indicating the date of service and **ALL three** of the following assessments:

1. Health and developmental history
2. Physical Examination
3. Health education/Anticipatory guidance

Children & Adolescent Access to Primary Care Practitioners

- Schedule your members 12 months to 19 years of age for the well-child visits
- Document and date well-child care services performed
- Code and submit claims AND encounter data

Cervical Cancer Screening

As of 2013, the Cervical Cancer Screening quality metric now measures the percentage of women who are screened for cervical cancer using either of the following criteria:

- Women age 21-64 who had cervical cytology performed every 3 years
- OR**
- Women aged 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years

When screening your patients for cervical cancer, please be sure to document the screening services provided in the patients' medical records and use the appropriate CPT codes to bill for the services.



Comprehensive Diabetes Care HbA1c Control < 8.0%

- Schedule your diabetic members for their annual lab screenings and exams
- Document and date services performed
- Code and submit claims **AND** encounter data

Comprehensive Diabetes Care Annual Retinal Eye Exam

- Schedule your diabetic members for their annual diabetic eye examinations
- If the eye examination is performed at your clinic:
 - Document and date when eye exam was performed
 - Code and submit claims **AND** encounter data for eye care services
- If you refer your patients to an eye care specialist:
 - Document and date results of the eye examination in your member's medical record.

SECTION 6: Expanded Criteria for Cervical Cancer Screening

NCQA has expanded the criteria for measuring compliance with the Cervical Cancer Screening measure.

Prior to 2013, the Cervical Cancer Screening quality metric measured only the percentage of women 21-64 years of age who had one or more Pap tests to screen for cervical cytology, during the measurement year.

As of 2013, the Cervical Cancer Screening quality metric now measures the percentage of women who are screened for cervical cancer using either of the following criteria:

- Women age 21-64 who had cervical cytology performed every 3 years.
- Women aged 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.

When screening your patients for cervical cancer, please be sure to document the screening services provided in the patients' medical records and use the appropriate CPT codes to bill for the services.



Codes to Identify Cervical Cancer Screening

CPT	HCPCS	UB Revenue	LOINC
88141-88143, 88147-88148, 88150, 88152- 88154, 88164- 88167, 88174-88175	G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091	0923	10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5

Codes to Identify Human Papillomavirus Screening

CPT	LOINC
87620, 87621, 87622	21440-3, 30167-1, 38372-9, 49896-4, 59420-0

SECTION 7: Provider Advisory Committee Meeting

The next GCHP Provider Advisory Committee (PAC) meeting will be held:

November 19, 2013
3:30 pm – 5pm
2240 E. Gonzales Rd. Suite 200
Large Conference Room
Oxnard, CA 93034