TheSource

Fall/Winter 2017

healthfirst®
Health Insurance for New Yorkers

IN THIS ISSUE

CONTACTS

Medical Management & Behavioral Health Unit
1-888-394-4327
Monday–Friday, 8:00am–6:00pm

Provider Services
1-888-801-1660
Monday–Friday, 9:00am–5:00pm

Fraud, Waste, & Abuse Anonymous Hotline
1-877-879-9137
Monday–Friday, 9:00am–5:00pm

Member Services: CHP, Medicaid
1-866-463-6743
Monday–Friday, 8:00am–6:00pm

Member Services: Medicare
1-888-260-1010
Monday–Friday, 8:00am–8:00pm

Member Services: Leaf Plans
1-888-250-2220
Monday–Friday, 8:00am–8:00pm

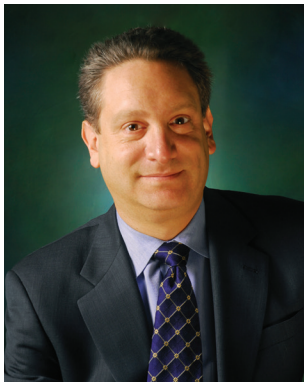
Member Services: Senior Health Partners
1-800-633-9717
Monday–Friday, 8:00am–8:00pm
Saturday, 10:00am–6:30pm

FIDA Participant Services
1-855-675-7630
Monday–Sunday, 8:00am–8:00pm

Member Services: TTY (All Products)
English: 1-888-542-3821
Spanish: 1-888-867-4132

Produced by:
Healthfirst Marketing and Brand & Creative Strategy

www.healthfirst.org/providers



From the desk of the

Chief Medical Officer

Dear Valued Provider:

Welcome to the Fall edition of *The Source*, Healthfirst's news magazine that delivers useful information that can help your practice care for our members, stay up-to-date on key initiatives, and navigate claims and compliance issues.

Understanding how physical, mental, and emotional health are intertwined is a growing area of focus for healthcare. Coordinating mental health and substance use disorders with primary care shows great promise for our members, as substance abuse and psychological distress (such as depression) are linked to poor outcomes for physical health. Please turn to page 16 to learn more about how Integrated Care can improve outcomes and how adult depression can be managed in the primary care setting.

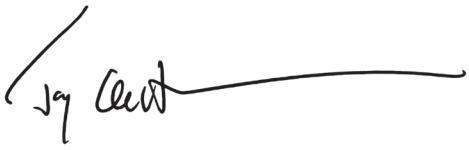
I want to remind our participating providers that Healthfirst members cannot be billed for the difference between the amount charged by your practice for services rendered and the amount reimbursed by Healthfirst. This "balance-billing" is a violation of your contract with us. To learn more, please turn to page 11.

This issue of *The Source* contains several announcements related to our pharmacy benefits and the regulations governing those benefits. Please turn to page 20 to read about the New York State law setting limits on dispensing controlled substances. Page 22 describes changes to Healthfirst's retail pharmacy network for Medicaid and Qualified Health Plans. Lastly, you should expect requests for additional information from CVS/Caremark in cases where you prescribe medications with utilization management requirements, a process discussed on page 26.

As usual, this issue of *The Source* contains many other important stories, everything from educational articles on cancer screenings to stories on cardiovascular health and well-child visits. I encourage you to review this issue closely.

Thank you for the care you provide to our members and for partnering with Healthfirst to improve the health and well-being of our communities.

Until next time,



Jay Schechtman, M.D., M.B.A.
Chief Medical Officer

Let us know what you think of ***The Source***. Send us an email at **source@healthfirst.org**.

Healthfirst's Newest Products:

Commercial EPO Plans for Individuals and Small Groups

Beginning January 1, 2017, Healthfirst will provide health insurance coverage to individuals and small businesses through Healthfirst Insurance Company, Inc., a wholly owned subsidiary of Healthfirst, Inc. Sold off the NY State of Health exchange, these plans will include Healthfirst Total EPO plans for individuals and Healthfirst Pro EPO and Healthfirst Pro Plus EPO plans for small groups. In addition to essential health benefits, these plans will offer benefits such as

- No-cost annual checkups
- $0 copay for telemedicine
- Coverage for acupuncture visits
- Options for comprehensive vision and dental coverage
- Up to $600 in exercise rewards for individuals and covered spouses
- All plans are non-gated
- Platinum, Gold, and Silver tier plans have PCP and specialist copays outside of the deductible

Beginning January 1, 2017, Healthfirst will provide health insurance coverage to individuals and small businesses through Healthfirst Insurance Company, Inc., a wholly owned subsidiary of Healthfirst, Inc.

Healthfirst Total EPO Plans for Individuals

With vision and dental benefits for members of all ages, Healthfirst Total plans are available to individuals and families residing in New York, Richmond, Queens, Kings, Bronx, and Nassau counties at four metal tiers: Platinum, Gold, Silver, and Bronze.

Individuals can enroll in a Total plan during open enrollment (now through January 31, 2017), with coverage beginning as early as January 1, 2017.

To enroll, interested individuals should call Healthfirst at **1-855-789-3668**, Monday to Friday, 8am–6pm.

Individuals can enroll in a Total plan during open enrollment (now through January 31, 2017), with coverage beginning as early as January 1, 2017.

Healthfirst Pro EPO and Pro Plus EPO Plans for Small Groups

Healthfirst's Pro and Pro Plus plans are similar in benefit design, but Pro Plus plans offer vision and dental benefits to members of all ages while Pro plans only cover vision and dental benefits for members under the age of 19. Both plans are available to New York small businesses (1–100 eligible employees) with employees who live, work, or reside in New York, Richmond, Queens, Kings, Bronx, and Nassau counties. Both Pro and Pro Plus plans are offered at four metal tiers: Platinum, Gold, Silver, and Bronze.

Small groups can now enroll in Pro and Pro Plus plans for coverage beginning as early as January 1, 2017.

Small-business owners interested in purchasing Pro or Pro Plus plans for their employees should contact their health insurance broker.

To learn more about Pro and Pro Plus plans, call Employer Services at **1-844-785-1652**, Monday through Friday, 9am–5pm, or visit **JoinHFPro.org**.

2017 Benefit Changes to Healthfirst Medicare Advantage Plans

Effective January 1, 2017, Healthfirst Medicare Advantage plans may include changes to benefits, premiums, copayments, coinsurance, deductibles, and formularies.

Healthfirst has important plan benefit changes coming in 2017. Effective January 1, 2017, Healthfirst Medicare Advantage plans may include changes to benefits, premiums, copayments, coinsurance, deductibles, and formularies. Our benefits have been reviewed and approved by the Centers for Medicare & Medicaid Services (CMS). You can help your Healthfirst patients better manage their healthcare costs by being aware of these changes.

What's Changing?

Most services will maintain the same cost-sharing as this year for most plans, including PCP/specialist visits, dental, vision, hearing, and transportation. Here's a quick summary of the benefit changes that will take place for some Healthfirst Medicare Advantage Plan members in 2017:

- Small copay increases in per-day inpatient, psychiatric hospital, and/or skilled nursing facility admissions
- Separate office-visit copays may apply to X-rays, outpatient diagnostic/therapeutic radiology, procedures, tests, and lab services
- Increased copay for ambulance services
- **NEW:** Healthfirst's Nurse Help Line
  - Toll-free nursing hotline offered to all plan members for $0
  - Members can call 24/7 for answers to general health-related questions and for assistance in accessing healthcare services

Need any additional details? Just visit **www.healthfirst.org/providers** to view the Evidence of Coverage for more comprehensive plan information on all our products.

My Patients Are Turning 65. What Are Their Options?

When patients of yours turn 65, they may have questions about their insurance options as they become eligible for Medicare. You can help your patients maintain affordable, high-quality coverage when they turn 65 by encouraging them to visit **www.medicare.gov**. There they can view plans available in their area and compare plans based on price and quality ratings.

Among their options is a Healthfirst Medicare Advantage plan. Healthfirst Medicare Advantage HMO plans are the only plans in NYC to achieve 4 stars out of a 5-star rating three years in a row, as rated by the Centers for Medicare & Medicaid Services. Healthfirst offers a variety of Medicare plans for all lifestyles and financial situations, including plans designed for low-income individuals who are eligible for Medicaid or Extra Help from Social Security to help them pay for prescription drug coverage.

Your patients can learn more about Healthfirst's Medicare plans by visiting the Healthfirst website at **www.healthfirst.org**, by coming to a local Healthfirst Help Center, or by calling us at **1-877-237-1303** (TTY 1-888-542-3821), 7 days a week, 8am to 8pm.

If you don't already participate in Healthfirst's Medicare Advantage plans, contact us to find out how you can.

Continued on pg. 8

My Patients Are Turning 65.

What Are Their Options?

Continued from pg. 7

As a Healthfirst provider, what am I allowed to tell my patients with regard to the plan?

The Centers for Medicare & Medicaid Services (CMS) has specific rules regarding provider-based activities. As such, providers are prohibited from acting as agents of Healthfirst or of any other Medicare health plan. When patients seek advice, you must remain neutral and ensure that you assist them in an objective assessment of their needs and potential options to meet those needs. Any assistance you give your patients that results in a Medicare plan selection must always be in the best interest of the beneficiary. Some key dos and don'ts are:

You may

- Make available Healthfirst Medicare Advantage marketing materials in common areas, as long as any other Medicare health plan that asks the same for their plans is accommodated. Please note that you cannot provide these materials within an exam room setting
- Refer your patients to other sources of information, such as the local Social Security Office or the CMS website at **www.medicare.gov**
- If your patient specifically asks about Healthfirst plans, you can refer them to our website at **www.healthfirst.org**
- Share information from the CMS website with your patients, including the *Medicare and You* handbook or the *Medicare Options Compare* or other documents that were written by or approved by CMS

You may not

- Accept enrollment applications or complete an enrollment application on behalf of a beneficiary
- Make phone calls or direct, urge, or attempt to persuade beneficiaries to enroll in a specific plan based on financial or any other interests you may have
- Send marketing materials on behalf of Healthfirst or any other Medicare health plan
- Offer anything of value to induce enrollees to select you as their provider of healthcare
- Offer inducements to persuade beneficiaries to enroll in Healthfirst or in any other Medicare health plan
- Accept compensation directly or indirectly from Healthfirst or any other Medicare plan for enrollment activities

What materials are available to providers?

You may contact Provider Services at **1-888-801-1660**, Monday to Friday, 8:30am–5:30pm, for provider-related information.

Additional resources for your Healthfirst Medicare Advantage patients who might need financial assistance

We know how hard it can be for some of your Healthfirst Medicare Advantage patients to keep up with all of the costs in their life—whether it's paying for rent, food, electricity, or medical bills. That's why we're pleased to tell you about **My Advocate**, a program open to **all Healthfirst Medicare Advantage members who may need financial help**.

With **My Advocate**, your Healthfirst Medicare Advantage patients get connected to local health and financial programs that offer:

- Medicine discounts
- Help with copays and Medicare Part B premiums
- Transportation discounts
- Meals and other food options
- Reduced rates for energy bills
- And more

Your Healthfirst Medicare Advantage patients may call **My Advocate** at **1-866-620-4995** (TTY 1-855-368-9643), Monday to Friday, 9am–6pm, or visit **My Advocate** at **www.myadvocatehelps.com** to find out which programs may be right for them. **My Advocate** will ask your patients questions about their finances to determine which programs they might be eligible to receive. All information will be kept private and confidential.

Refer Your Patients In-Network to Avoid Surprise Bills

Remember, your Healthfirst patients can avoid large and unnecessary healthcare bills by visiting in-network doctors, hospitals, specialists, and urgent care centers. With the exception of emergency care, Healthfirst plans do not cover out-of-network treatment. By staying in-network, your Healthfirst patients will still be responsible for the cost-sharing amounts determined by their plan, but you can help ensure they don't pay more than they need to by directing them to **www.HFDocFinder.org** to find in-network care.

Renewal Changes and Open Enrollment Dates

Open Enrollment is here. Here are a few updates and reminders to be aware of so you can best advise your patients:

- Effective 2/1/17, Child Health Plus members will no longer receive a recertification packet from Healthfirst; instead, they will receive a letter with instructions on how to renew through the NYSOH Marketplace
- Medicaid members who become Essential Plan-eligible will be moved to the NYSOH Marketplace for renewal on their anniversary date
- Open Enrollment for Qualified Health Plans is 11/1/16 to 1/31/17; Special Enrollment via a Qualified Life Event is year-round
- Medicaid, Child Health Plus, and Essential Plan enrollment is year-round

If your patients have any questions about enrollment or renewals, they may:

- Call Healthfirst Member Services at **1-866-463-6743** (TTY 1-888-542-3821), Monday to Friday, 8am–6pm
- Visit us online at **www.HFRenew.org**

Participating Providers CANNOT Balance-Bill Members

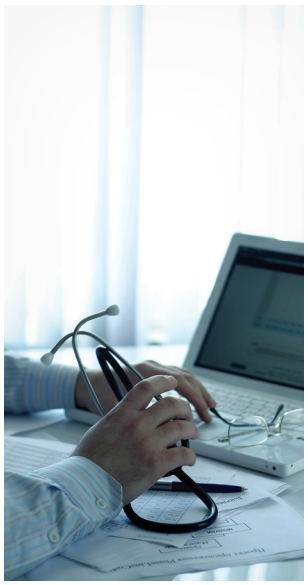
Remember, balance-billing Healthfirst members for any covered services is *strictly prohibited!* This means that, as a provider, you cannot bill a member for the difference between the amount you charge for services rendered and the amount you have been reimbursed by Healthfirst. Any such billing is a violation of the provider's contract with Healthfirst, and applicable Federal and New York State laws will apply. Providers can bill our members for the following:

- Applicable copays
- Coinsurance, and/or
- Deductibles

Also, per CMS, dual-eligible members will not have any cost-sharing responsibilities for Medicare services when the state is responsible for paying those amounts. Here are some extra details:

- Providers must accept Healthfirst's payment as payment in full or bill the appropriate state source (i.e., Medicaid FFS)
- Requirement applies to all dual-eligible individuals and not just to members enrolled in a Medicare Advantage Dual Eligible Special Needs Plan (SNP) or Medicare-Medicaid Plan (MMP)

For more information, we invite you to browse and download our provider manual, which can be found at **www.hfprovidermanual.org**. If you have any additional questions, please contact your Healthfirst Network Account Manager or call Provider Services at **1-888-801-1660**.



Remember, balance-billing Healthfirst members for any covered services is *strictly prohibited!*

Improving Patient Satisfaction in Your Practice

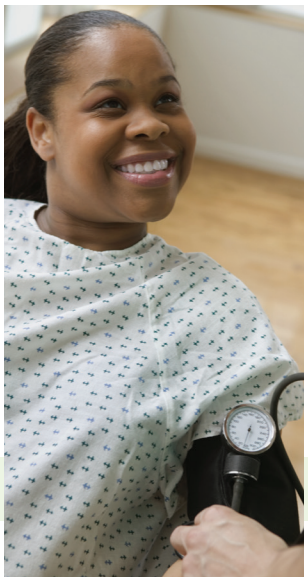
The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for Medicaid members is administered between September and December. Your Healthfirst Medicaid patients evaluate their satisfaction through the CAHPS survey, which provides information that is then used to improve care and the patient experience. The survey impacts quality ratings and the financial resources we have available to support your practice.

The CAHPS survey covers topics that are important to consumers and focuses on aspects of access and quality that assess their experience with care. The key topics covered are Getting Needed Care, Getting Care Quickly, and Coordination of Care.

Improving patient satisfaction may lead to increased patient engagement and better health outcomes. How you communicate and act with your patients helps them feel more comfortable, and they are then better able to understand what is going on with their health and the importance of following through with a treatment plan.

If you are eligible for the Healthfirst Quality Incentive Program (HQIP), improving satisfaction can also improve your performance on those metrics, thereby increasing the incentive payments earned for your practice or organization.

Visit **www.healthfirst.org/patientsatisfaction** to learn more about the areas to focus on for improvement, best practices, and links to helpful resources for you and your Healthfirst members.



Additional resources:

Safety Net Medical Home Initiative **(www.safetynetmedicalhome.org)** — a library of resources and tools to help your practice understand and implement the Patient-Centered Medical Home (PCMH) Model of Care. Learn more about the framework they developed for PCMH transformation—the "Change Concepts for Practice Transformation"—and get access to implementation guides, assessment tools, and presentations.

The Microsystem Academy at The Dartmouth Institute for Health Policy and Clinical Practice **(www.clinicalmicrosystem.org/improving-access-to-care)** provides education and coaching tools and resources to help organizations achieve successful practice transformation.

Help Improve Quality Scores by Complying with Chart Review Requests

Prompt responses to chart review requests help Healthfirst in a variety of ways: to remain compliant with CMS audits, to improve risk scores, and to increase our quality ratings. As you're aware, our quality scores are tied directly to the Healthfirst Quality Incentive Program, which incentivizes our providers to offer the best possible care to their patients and our members—because when we work together to provide exceptional healthcare, good things happen.

Annual Provider Update

Each year, Healthfirst is required to share important regulatory and compliance information with its providers, as well as reference materials that help with understanding our programs and benefits.

We are pleased to announce that you can now access the following important documents directly from our website by going to **www.healthfirst.org/provider-annual-update.html**:

- Access to Medical Care for Individuals with Mobility Disabilities
- Americans with Disabilities Act Commonly Asked Questions
- Audiology Coverage Updates
- Bilateral Procedure Billing Guidelines
- CDC Immunization Schedule 0–18 yrs.
- Communicable Disease Reporting Requirements
- Cultural Competence Orientation
- Domestic Violence – Finding Safety and Support
- EFT Authorization Form
- ERA Provider Set-Up Form
- eviCore Radiation Therapy Management Program
- Expanded Network of Diagnostic and Specialty Laboratory Providers
- FDR & Affiliate Compliance Guide
- FIDA Required Provider Training Information and Frequently Asked Questions
- Healthfirst Clinical Practice Guidelines and Protocols
- Healthfirst FDR and Affiliate Compliance Attestation
- Healthfirst Formulary
- Healthfirst Model of Care
- Healthfirst Policy on Provider Access and Availability
- Healthfirst Provider Manual
- Healthfirst Provider Orientation: Medicare
- Healthfirst Quick Reference Guides
- HEDIS Codes–All Measures
- Healthfirst Smoking Cessation Flyer
- High-Risk Medication Reference Material
- High-Risk Medications List for Website

- Important Changes in Coverage for Viscosupplementation and Related Codes
- Important Changes in Coverage of Genetic Testing Services
- Inpatient Nursing Home Billing Guidelines
- IRS Form W-9
- Medicare Appointment of Representative Form
- New CMS Modifiers for Distinct Procedural Services (59 Modifier)
- New Payment Policies Affecting Drugs & Biological Agents
- New York City Department of Health–Treating Tobacco Addiction
- New York State Department of Health AIDS Institute–Provider Guide to HIV Testing
- Observation Stay Billing Guidelines
- OrthoNet Codes Requiring Authorizations
- Provider Frequently Asked Questions about NY State of Health and Healthfirst Commercial Plans (Leaf Plans)
- Say Yes to the Test: Why Testing for HIV Should Become Routine in Your Practice Setting
- Say Yes to the Test Consumer Brochure
- Social Adult Day Care Centers (SADC) Annual Certification Requirement
- Superior Vision Authorization Form
- Superior Vision: Codes Requiring Authorization
- If you have any questions about the information in the Annual Update, please contact Provider Services at **1-888-801-1660** or send an email to **providerservices@healthfirst.org**.

Clinical Partnerships

Spectrum of Health—Integrated Care

Management of mental health conditions and substance use disorders involves both prevention and chronic care management. Our members set personal health goals that are focused on practical health outcomes: to be healthy, to feel well, and to avoid premature death. Achieving optimal physical health cannot be disconnected from optimal mental health.

Using New York State Department of Health (NYS DOH) Statewide Planning and Research Cooperative System (SPARCS) 2014 data, an assessment of chronic condition categories (AHRQ CCS) and codes demonstrates that about 27% of all adult hospital inpatient discharges involved patients with major mental behavioral health conditions: mental illness, alcohol abuse, and/or other substance abuse conditions. Of these, two-thirds had at least two other forms of physical health chronic disease. More than half of these patients were estimated to be living with a significant social functional impairment, including, but not limited to, managing violent behavior, maintaining relationships, holding a job, and/or retaining a place to live in the community.[1]

Our members set personal health goals that are focused on practical health outcomes: to be healthy, to feel well, and to avoid premature death.

For patients, physical, mental, and emotional health needs are intertwined. The solution lies in integrating care; that is, in coordinating mental health and substance use disorders with primary care. Integrated care has proven to be the most effective approach to care and service for people with complex healthcare needs.[2]

Ultimately, our shared aspiration is early identification and management to goal for your patients who are at risk for future or actual chronic physical, behavioral, and/or substance use disorders. Thank you for all that you do to achieve the best health outcomes for our members.

[1]New data on prevalence and severity of behavioral health conditions among 2014 general hospital inpatients in New York State. Prepared by the Arthur Webb Group, March 2016. Accessed April 6, 2016.

[2]Woltmann E, Grogan-Kaylor A, Perron B, Georges H, Kilbourne AM, & Bauer MS (2012). Comparative effectiveness of collaborative chronic care models for mental health conditions across primary, specialty, and behavioral health care settings: systematic review and meta-analysis. American Journal of Psychiatry, 169(8), 790–804.

What Is Integrated Care and How Does it Improve Outcomes?

Integrated Care is the meshing of behavioral health and substance use disorder screening, treatment, and monitoring concomitantly with all physical health needs.[3] This strategic approach to caring for patients addresses the whole person. The evidence indicates that use of Integrated Care to improve outcomes results in a reduced burden of disease and decreases the rates of emergency room visits and subsequent hospitalizations.[4]

Behavioral health and substance use disorders affect a significant proportion of the U.S. population. In fact, nearly half of all Americans develop a mental illness during their lifetime.[5] According to the National Institute of Mental Health, in 2014 there were an estimated 43.6 million adults aged 18 or older in the United States with some form of mental illness. This number represented 18.1% of all U.S. adults.

New York State, like other states over the past decade, has been prompting primary care practice transformation with patient-centered medical homes for Medicaid patients who are seriously ill. For behavioral health, the NYS Office of Mental Health has developed a partnership with the Department of Health to collaborate with health plans and providers statewide to improve outcomes for those who have serious mental illness.[6]

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Psychological distress is directly linked to poor outcomes for physical health.

THE PROBLEM

People with mental illness die earlier than the general population and have more co-occurring health conditions

68%
of adults with a mental illness have one or more chronic physical conditions

MORE THAN
1 in 5
adults with mental illness have a co-occurring substance use disorder

Source: www.integration.samhsa.gov.

Case Studies: Do you recognize these patients?

Your reliable patient denies stress at home or work but begins to "forget" medical appointments or to pick up medications.

A teen parent is living with multiple stresses such as inadequate preparation for parenting, housing insecurity, and/or education instability. You are concerned that s(he) is at risk for poor medical outcomes and depression postpartum.

A senior adult with mild dementia develops poor dietary control, incontinence, inconsistent medication schedules, and episodes of lashing out. Is this a signal that there is an underlying mood disorder or increased alcohol intake?

A family in your practice may state that nothing is wrong, yet you suspect that there is post-traumatic stress disorder connected to their recent immigration to the United States.

[3]www.integration.samhsa.gov/about-us/what-is-integrated-care. Accessed May 16, 2016.

[4]www.integration.samhsa.gov/research. Accessed May 17, 2016.

[5]www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-us-adults.shtml. Accessed May 17, 2016.

[6]www.health.ny.gov/health_care/medicaid/redesign/docs/1115_waiver_behavioral_health_amendment.pdf. Accessed May 16, 2016.

Clinical Partnerships

Continued from pg. 17

Managing Adult Depression in Primary Care

The Healthfirst Quality Improvement Committee has approved a standard approach to the screening, assessment, and management of adult depression based on the Institute for Clinical Systems Improvement (ICSI) Health Care Guideline for managing "Depression in Primary Care" ("Guideline").[7] A full copy of the ICSI Guideline can be accessed here: **www.icsi.org/_asset/fnhdm3/Depr-Interactive0512b.pdf**.

The first recommendation is to routinely screen all adults for depression using validated and reliable instruments such as screening and tracking tools to enhance the clinical interview of patients. The Guideline highlights the PHQ-2 and the strong evidence for use of the PHQ-9 in patients with chronic disease.

According to the Guideline, "Risk factors for major depression include:

- Family or personal history of major depression and/or substance abuse
- Recent loss
- Chronic medical illness
- Stressful life events that include loss (death of a loved one, divorce)
- Traumatic events (e.g., car accident)
- Major life changes (e.g., job change, financial difficulties)
- Domestic abuse or violence"

According to the Guideline, key steps following a potential diagnosis of depression are to:

- Characterize the major depression/persistent depressive disorder with clinical interview
- Determine if the patient is safe to self and/or others
- Implement protocol to assess and minimize suicide risk, which may involve mental health specialists
- Assess for the presence of substance use disorder or psychiatric comorbidity if suspected

Once depression is diagnosed and characterized, the Guideline outlines milestones in creating a comprehensive treatment plan. These include:

- Discussing treatment recommendations to achieve remission and/or a patient that is predominantly symptom-free (i.e., a PHQ-9 score of less than five), with recommended use of shared decision-making as the process to do so
- Behavioral activation as an evidence-based intervention, including appropriate physical activity
- Implement protocol to assess and minimize suicide risk, which may involve mental health specialists
- Assess for the presence of substance use disorder or psychiatric comorbidity if suspected

[7]Trangle M, Gursky J, Haight R, Hardwig J, Hinnenkamp T, Kessler D, Mack N, Myszkowski M. Institute for Clinical Systems Improvement. Adult Depression in Primary Care. Updated March 2016.

A follow-up plan should be established which includes an assessment of:

- Whether the patient reached remission
- Continuation and maintenance treatment duration based on episode
- Use of a stepped-care approach to achieve improvement if patient shows no improvement on initial treatment

The Guideline also stresses that "A collaborative care approach is recommended for patients with depression in primary care." Because the quality of the evidence is high, such an approach is strongly recommended.[8]

Finally, the Guideline recommends four key components in the design of a team-based collaborative care approach based on Unützer, 2002:

- Primary care clinicians using evidence-based approaches to depression care, and a standard tool for measuring severity, response to treatment plan, and remission
- A systematic way of tracking and reminding patients at appropriate intervals of visits with their primary care physician and monitoring of treatment adherence and effectiveness
- A team member (care manager role) to utilize the tracking system, to make frequent contact with the patients to provide further education and self-management support, and to monitor for response in order to aid in facilitating treatment changes and in relapse prevention
- Communication between primary care team and psychiatry to consult frequently and regularly regarding patient under clinical supervision, as well as direct patient visits as needed[9]

You may download the full *Spectrum of Health* bulletin on Integrated Care at **www.healthfirst.org/ClinPartnerships**. The bulletin highlights:

- Current standards for mood and substance abuse screening and assessment
- Effective alternatives for integrating healthcare for your patients
- HEDIS requirements measuring behavioral health and substance abuse disorders
- Best practices and tools for the integrated approach to patient health

Spectrum of Health bulletins covering frailty and fall risk, colorectal cancer, smoking cessation, and heart failure are also available.

[8]ibid.

[9]Unützer et al. Collaborative Care Management of Late-Life Depression in the Primary Care Setting: A Randomized Controlled Trial; JAMA. 2002;288(22):2836–2845. doi:10.1001/jama.288.22.2836.

Pharmacy News

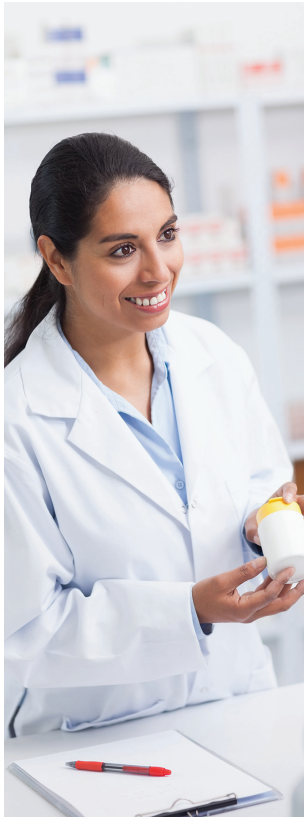
NYS State Law on Controlled Substances, Allowable Limits

Did you know that if you call in a prescription for a controlled substance for a Medicaid patient the pharmacy is allowed to dispense only a limited supply? This NY State law went into effect in August 2014.

Telephonic or faxed orders for controlled substances must comply with the following requirements:

- **Schedule II controlled substances and Schedule IV benzodiazepines –** in an emergency, may be orally prescribed up to a 5-day supply
- **Schedule III and V controlled substances –** may be orally prescribed up to a 5-day supply
- **Schedule IV controlled substances (excluding benzodiazepines) –** may orally be prescribed for the lesser of a 30-day supply or 100 dosage units

Faxed prescriptions for controlled substances must comply with requirements for oral prescriptions for controlled substances.



Requests for Information from CVS/Caremark

When you prescribe medications that have utilization management requirements, CVS/Caremark will likely need some additional information before authorizing the prescription. Depending on whether your patient is Medicaid or Medicare, different rules apply. Also, where you send your information within Caremark is different: Medicaid is handled in one center; Medicare in another. Each center has its own phone and fax numbers (see below for a complete list of contact information). Please note that the Medicaid/Child Health Plus center handles the Personal Wellness Plan (PWP).

For Medicaid members who have dual eligibility (meaning they also have Medicare), Medicare is the primary payer; all criteria forms should be sent to the Medicare Part D center. When you send the criteria form for a dual-eligible patient to the Medicaid Prior Authorization center, you are risking a delay in the processing of the request.

Please use the appropriate form when requesting coverage approval and send to the proper CVS/Caremark center.

- For Medicaid only, use the Medicaid form
- For Medicare and dual-eligible patients, use the Medicare form

These forms can be found on the Healthfirst website, under Provider Resources: **www.healthfirst.org/providers/provider-resources**.

CVS/Caremark* Prescriber Contact Information

For current Healthfirst formularies and other prescription benefit information, please visit **www.healthfirst.org/providers/provider-resources**.

	Medicaid & Child Health Plus	Medicare Part D	AbsoluteCare FIDA	Leaf Plans
Prior Authorization Coverage Determinations	1-877-433-7643	1-855-344-0930	1-855-675-7630	1-855-582-2022
Appeals	1-855-465-0027	1-855-344-0930	1-877-779-2959	1-855-582-2022
Mail Order Pharmacy	1-800-378-5697	1-800-378-5697	1-800-378-5697	1-800-378-5697
Specialty Pharmacy (For prescribing or requesting a Prior Authorization for a specialty drug)	1-866-814-5506	1-866-814-5506	1-866-814-5506	1-866-814-5506

*CVS/Caremark provides Healthfirst with pharmacy benefit management services, including all prescription drug-related Prior Authorizations and Appeals.

As a final note on getting your requests successfully processed, please remember that Healthfirst is bound by regulation to process Medicare coverage determination requests 7 days per week, 24 hours per day. This means that if we get an urgent request from a member on a Saturday, we will need to contact you for information and provide a response to the member within 24 hours. If we cannot reach you, we must deny the member's urgent request for medication. Below is a list of the timeframes we must abide by. If we cannot get a response from you, your patient cannot get the medication you prescribed.

Medicare Initial Coverage Determination:

- Prior Authorization
  - Standard – **72 hours** from request
  - Expedited – **24 hours** from request
- Exception
  - Standard – **72 hours** from prescriber's statement
  - Expedited – **24 hours** from prescriber's statement

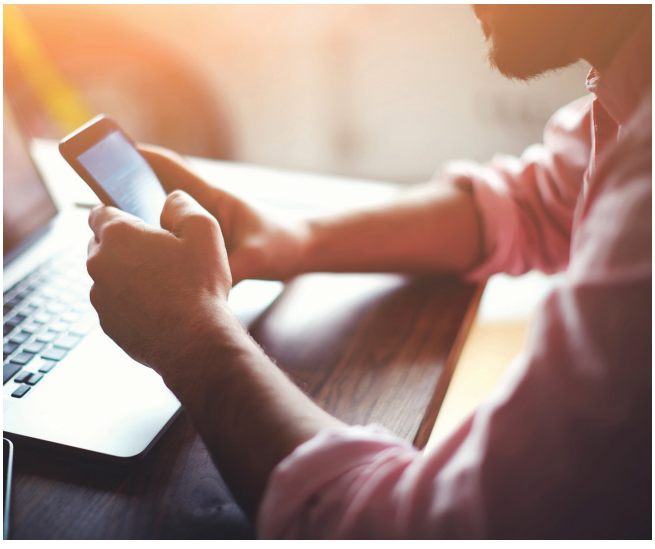
Medicare Redetermination (or appeal):

- Standard – **7 calendar days** from request
- Exception – **72 hours** from request

Medicaid Prior Authorization:

- Standard – 14 calendar days
- Expedited – **72 hours**

Your assistance in a timely response to requests from CVS/Caremark will ensure that your patients receive their medications as needed.
We at Healthfirst thank you for your cooperation.



Changes to the Retail Pharmacy Network

Healthfirst has changed its retail pharmacy network. This change affects the following plans: Healthfirst Leaf and Leaf Premier plans, Healthfirst Essential Plan, and Healthfirst Medicaid and Child Health Plus.

(Note: Healthfirst Medicare HMO plans are not included in this change. The Healthfirst Personal Wellness Plan is excluded from this implementation until mid-2017.)

Members will benefit from having Healthfirst Leaf and Leaf Premier plans, Healthfirst Medicaid, and the Healthfirst Essential Plan aligned under the same retail pharmacy network.

We understand that changes to the pharmacy network could impact your patients as well as your office staff. To minimize disruption to you, your staff, and your patients, Healthfirst has taken the following actions:

- Members most likely to be affected by these changes were sent letters detailing the changes. These letters included a list of the three pharmacies in closest proximity to the member's residence
- A provider communication strategy was developed, including:
  - A targeted mailing to prescribers, which included a listing of their patients who have filled prescriptions at pharmacies that are no longer in the Healthfirst network
  - A listing of all the pharmacies that are no longer in the network, including information about the closest one in the new pharmacy network
  - An updated, full pharmacy directory (online directory at **www.hfdocfinder.org**)
  - Additional support for members who are confused about these changes or who require additional assistance; please direct them to call the phone number on the back of their member ID card
- Administration of a transition-fill process that will allow patients to fill their medications one more time (up to a 30-day supply) within 90 days of the effective date

Although most pharmacies are still available to serve Healthfirst members, some pharmacies in the current Healthfirst pharmacy network will be out-of-network.

How is Healthfirst's pharmacy network changing?

Although most pharmacies are still available to serve Healthfirst members, some pharmacies in the current Healthfirst pharmacy network will be out-of-network.

It's possible that a patient's current pharmacy may be out-of-network. If this is the case, it's important to let them know that they must switch to a participating network pharmacy in order to ensure their prescriptions are covered.

If they need help to get a prescription from a pharmacy that is not in our network, please have them call the Member Services phone number on their ID card.

Why is Healthfirst changing the pharmacy network?

The new pharmacy network satisfies the needs of our Leaf and Leaf Premier plans, our Essential Plans, and our Medicaid and Child Health Plus plans. By aligning our pharmacy network across these plans, we're removing the potential for disruption when members move to and from these plans.

What are my next steps?

Please make sure your patients use a pharmacy that is in Healthfirst's robust network:

- Have your patients visit our online directory at **www.hfdocfinder.org** or call our Member Services to check the status of their preferred network pharmacy
- If their pharmacy is no longer listed in the directory, they'll need to find a new preferred pharmacy. They may choose from any of the other in-network options available

How can Healthfirst members find a list of pharmacies in the new network?

Finding a new participating pharmacy is easy—your patients can visit our online directory at **www.hfdocfinder.org**, walk into a Healthfirst Help Center in their neighborhood, or call Healthfirst Member Services and ask a representative for assistance.

How can patients have their prescriptions transferred from their current pharmacy to one that participates in the new network?

Moving their current prescriptions is easy. They can use one of these options:

- Simply call Healthfirst Member Services and select prompt #3 for Pharmacy. A representative will make sure their refills are moved to a network pharmacy of their choice
- They can also take their medicine bottle (which has the information needed to move their prescription) into the new drugstore and tell them they'd like their medications moved to that pharmacy. Please note that controlled substances and new prescriptions are prohibited from transferring

Paint the Most Accurate Picture of Your Patient's Health Profile

It has been reported that 60% of the 1.2 billion clinical documents that the US produces each year* contain valuable clinical data stuck in unstructured documentation that is inaccessible for clinical use and quality measurement.

The constantly changing landscape of the healthcare system requires diligence in ensuring that your patients' chronic conditions are accurately documented and coded, and that they are reported regularly (at **least** annually). Paying attention to the detailed requirements now will enable you to:

- demonstrate the complexity and high quality of the care you provide to your members
- ensure that patients receive the right care at the right time
- demonstrate adherence to Quality Measure standards

The most efficient way to communicate the information data is through claims data.

With ICD-10-CM, it is important to document and report **all** of the medical diagnoses and comorbidities, because it:

- Accurately defines the illness burdens of the patient
- Helps improve care coordination and communication
- Improves patient outcomes and patient experience
- Enhances care decisions, which are based on complete and accurate information
- Supports medical necessity

How can you effectively and efficiently communicate your patients' health status?

1. Capture and report all chronic conditions at **least** annually
2. Link the causal relationship between the condition and the manifestations/complications
3. Document and report all "status" conditions at **least** annually. Examples are:
   a. Obesity/morbid obesity and BMI measurements
   b. Presence of artificial openings (colostomy, nephrostomy, G-tube)
   c. Post-amputation status
4. Apply M.E.A.T.† to ensure coding accuracy
   a. **M**onitor – signs and symptoms, disease progression/recession
   b. **E**valuate – test results, medication effectiveness, treatment response
   c. **A**ssess/Address – review records, order diagnostic tests, discuss and counsel. Review all specialist notes, consultations, discharge summaries, labs and diagnostic tests
   d. **T**reat – medications, therapies, referrals, other modalities

A fully documented medical record and accurate coding provide greater insight into the complexities of your patients' health and allows Healthfirst to more precisely reflect on your patients' actual health risk factors through care coordination, education, enrollment in specific disease programs, arranging for transportation, and many other services.

*DataconomyMedia; March 10, 2016.

†Put Meat in Documentation for Healthy Adults; Capstone Performance Systems; 10/7; www.capstoneperformancesystems.com/articles/put-meat-in-documentation-for-healthy-audits.

Medical Orders for Life-Sustaining Treatment (MOLST)

Honoring patient preferences is a critical element in providing quality end-of-life care. To help physicians and other healthcare providers discuss and convey a patient's wishes regarding cardiopulmonary resuscitation (CPR) and other life-sustaining treatment, the Department of Health has approved a physician order form—**(DOH-5003), Medical Orders for Life-Sustaining Treatment (MOLST)**—which can be used statewide by healthcare practitioners and facilities. MOLST is intended for patients with serious health conditions who:

- Want to avoid or receive any or all life-sustaining treatment
- Reside in a long-term care facility or require long-term care services and/or
- Might die within the next year

Completion of the MOLST begins with a conversation or a series of conversations among the patient; the patient's healthcare agent or surrogate; and a qualified, trained healthcare professional who defines the patient's goals for care, reviews possible treatment options on the entire MOLST form, and ensures shared, informed, medical decision-making. Although any qualified and trained healthcare professional may initiate the conversation(s) about goals and treatment options, a licensed physician must always, at a minimum, (i) confer with the patient and/or the patient's healthcare agent or surrogate about the patient's diagnosis, prognosis, goals for care, treatment preferences, and consent by the appropriate decision-maker, and (ii) sign the orders derived from that discussion.

Completion of MOLST begins with a conversation or a series of conversations among the patient.

Source

www.health.ny.gov/professionals/patients/patient_rights/molst/.

The MOLST form is one way of documenting a patient's treatment preferences concerning life-sustaining treatment—providers may choose to use other forms. However, under State law, the MOLST form is the only authorized form in New York State for documenting both non-hospital DNR and DNI orders. In addition, the form is beneficial to patients and providers, as it provides specific medical orders and is recognized and used in a variety of healthcare settings.

For detailed MOLST requirements including checklist and instructions for Adults, Minors and Persons with Mental Illness or Developmental Disabilities Who Lack Decision-Making Capacity, visit the **New York State Department of Health Medical Orders for Life-Sustaining Treatment (MOLST)** website.

The American Cancer Society recommends these cancer screenings for most adults

Breast cancer	■ **Women ages 40 to 44** should have the choice to start annual breast cancer screening with mammograms (X-rays of the breast) if they wish to do so ■ **Women ages 45 to 54** should get mammograms every year ■ **Women 55 and older** should switch to mammograms every two years or can continue yearly screening ■ Screening should continue as long as a woman is in good health and is expected to live 10 more years or longer ■ **All women** should be familiar with the known benefits, limitations, and potential harms linked to breast cancer screening. They also should know how their breasts normally look and feel, and should report any breast changes to a healthcare provider right away
Colon and rectal cancer and polyps	Starting at age 50, both men and women should follow one of these testing plans: **Tests that find polyps and cancer** ■ Flexible sigmoidoscopy every five years*, or ■ Colonoscopy every 10 years, or ■ Double-contrast barium enema every five years*, or ■ CT colonography (virtual colonoscopy) every five years* **Tests that mostly find cancer** ■ Yearly guaiac-based fecal occult blood test (gFOBT)**, or ■ Yearly fecal immunochemical test (FIT)**, or ■ Stool DNA test (sDNA) every three years*

*If the test is positive, a colonoscopy should be done.

**The multiple stool take-home test should be used. One test done in the office is not enough. A colonoscopy should be done if the test is positive.

Cervical cancer	■ **Cervical cancer testing should start at age 21.** Women under age 21 should not be tested ■ **Women between the ages of 21 and 29** should have a Pap test done every three years. HPV testing should not be used in this age group unless it's needed after an abnormal Pap test result ■ **Women between the ages of 30 and 65** should have a Pap test plus an HPV test (called "co-testing") done every five years. This is the preferred approach, but it's OK to have a Pap test alone every three years ■ **Women over age 65** who have had regular cervical cancer testing in the past 10 years with normal results should not be tested for cervical cancer. Once testing is stopped, it should not be started again. Women with a history of a serious cervical pre-cancer should continue to be tested for at least 20 years after that diagnosis, even if testing goes past age 65 ■ **A woman who has had her uterus and cervix removed (a total hysterectomy)** for reasons not related to cervical cancer and who has no history of cervical cancer or serious pre-cancer should not be tested ■ **All women who have been vaccinated against HPV** should still follow the screening recommendations for their age groups
Endometrial (uterine) cancer	■ The American Cancer Society recommends that at the time of menopause all women should be told about the risks and symptoms of endometrial cancer. Women should report any unexpected vaginal bleeding or spotting to their doctors

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The American Cancer Society recommends these cancer screenings for most adults

Continued from pg. 27

Lung cancer	The American Cancer Society does not recommend tests to check for lung cancer in people who are at average risk. But they do have screening guidelines for those who are at high risk of lung cancer due to cigarette smoking. Screening might be right for you if you are all of the following: ■ 55 to 74 years of age ■ In good health ■ Have at least a 30 pack-year smoking history AND are either still smoking or have quit within the last 15 years (A pack-year is the number of cigarette packs smoked each day multiplied by the number of years a person has smoked. Someone who smoked a pack of cigarettes per day for 30 years has a 30 pack-year smoking history, as does someone who smoked two packs a day for 15 years.) Screening is done with an annual low-dose CT scan (LDCT) of the chest. If you fit the list above, talk to a healthcare provider if you want to start screening.
Prostate cancer	The American Cancer Society recommends that men make an informed decision with a healthcare provider about whether to be tested for prostate cancer. Research has not yet proven that the potential benefits of testing outweigh the harms of testing and treatment. We believe that men should not be tested without first learning about what we know and don't know about the risks and possible benefits of testing and treatment. Starting at age 50, men should talk to a healthcare provider about the pros and cons of testing so they can decide if testing is the right choice for them. If you are African American or have a father or brother who had prostate cancer before age 65, you should have this talk with a healthcare provider starting at age 45. If you decide to be tested, you should get a PSA blood test with or without a rectal exam. How often you're tested will depend on your PSA level.

Cancer-related checkups

For people age 20 or older who get periodic health exams, a cancer-related checkup should include health counseling and, depending on a person's age and gender, exams for cancers of the thyroid, oral cavity, skin, lymph nodes, testes, and ovaries, as well as for some diseases other than cancer.

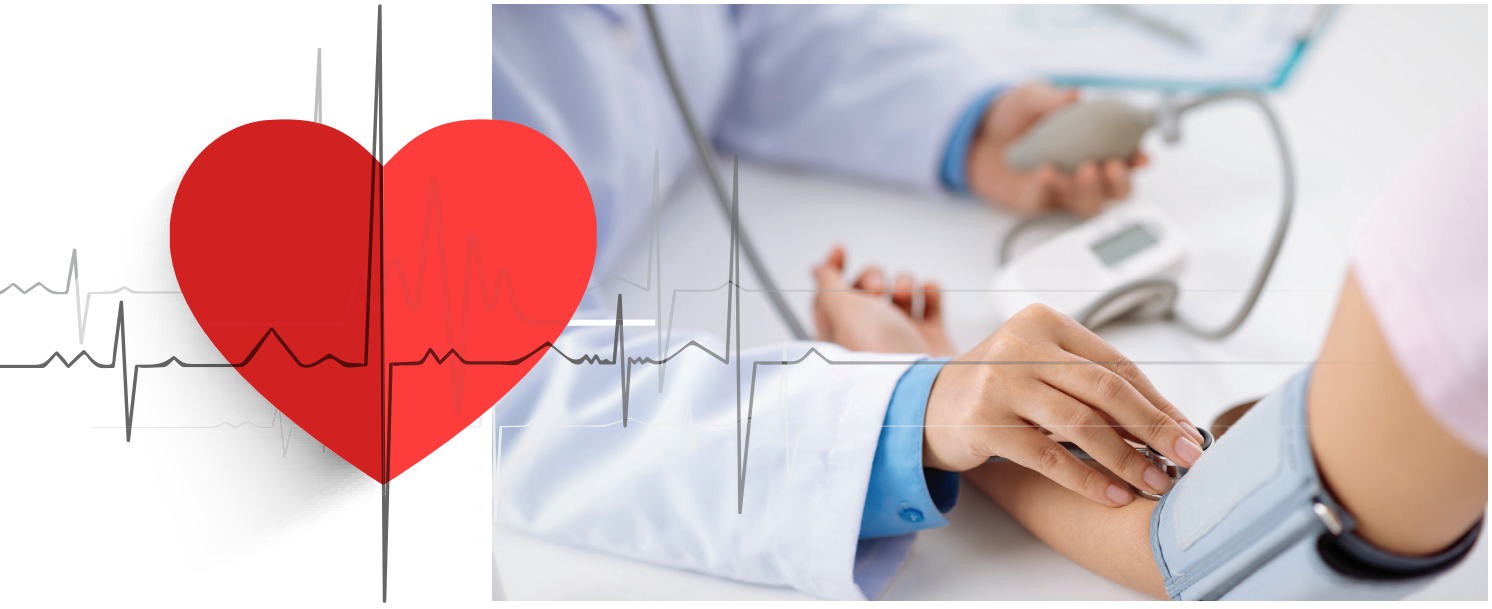
Some patients (based on their history and other factors) may need to be screened more frequently. Talk to your patients about their risks and the plan that is best for them.

Source

www.cancer.org/healthy/findcancerearly/cancerscreeningguidelines/american-cancer-society-guidelines-for-the-early-detection-of-cancer.

Reduce the risk of cardiovascular disease

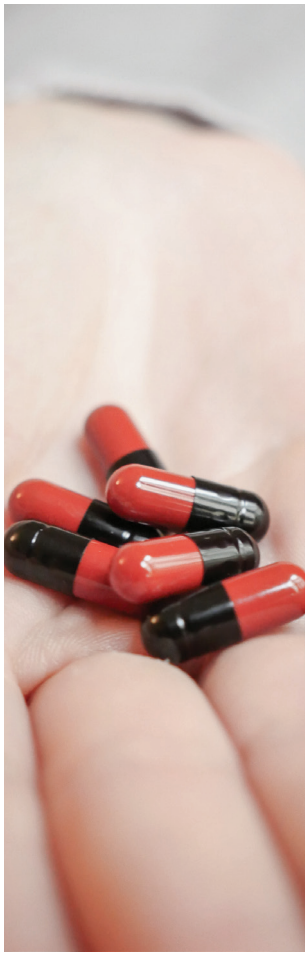
According to the American Heart Association, medication non-adherence is prevalent among patients with cardiovascular disease in the United States. Studies show that 24% of individuals who had a heart attack do not fill their prescriptions within seven days of discharge,[10] and 34% of patients who suffered from a heart attack and have multiple prescriptions stop taking at least one of them within one month of discharge.[11]



[10]Jackevicius CA, Li P, Tu JV. Prevalence, predictors, and outcomes of primary nonadherence after acute myocardial infarction. Circulation. 2008; 117: 1028–1036.

[11]Ho PM, Spertus JA, Masoudi FA, Reid KJ, Peterson ED, Magid DJ, Krumholz HM, Rumsfeld JS. Impact of medication therapy discontinuation on mortality after myocardial infarction. Arch Intern Med. 2006; 166: 1842–1847.

Below are **SIMPLE** tips from the Centers for Disease Control & Prevention and the Centers for Medicare & Medicaid Services on how to improve medication adherence among patients with heart disease:



Simply the regimen: Encourage the use of self-management tools like day-of-the-week pillboxes or mobile apps; recommend taking the medication during daily routine activities (e.g., mealtime, bedtime, with other medications they are already taking, etc.).

Impart knowledge: Be clear when writing prescription instructions and verbally reinforce them; give additional education and online resources.

Modify patients' beliefs and behavior: Positively reinforce patients when they take their medication as you prescribed; offer incentives if feasible; try to understand and address patients' concerns or fears.

Provide communication and trust: Let patients talk freely; speak to patients in plain language (e.g., instead of using the word "adherence", ask "did you take all of your pills?); request patient feedback on your recommendations; remind them to contact your office with any questions.

Leave the bias: Inquire about the patient's attitudes, beliefs, and cultural norms that impact how he or she views taking medications; be sensitive to the psychosocial factors that impede medication adherence and intervene as necessary.

Evaluate adherence: Be direct when asking patients if they are compliant with their medication regimen; use a medication adherence scale like the Morisky-8 (MMAS-8), Morisky-4 (MMAS-4, or Medication Adherence Questionnaire), Medication Possession Ratio (MPR), or Proportion of Days Covered (PDC).

Inquire about the patient's attitudes, beliefs, and cultural norms that impact how he or she views taking medications...

As a Healthfirst provider, you are essential in empowering our cardiovascular patients with the education and tools to reduce their risk of heart attack or stroke. Please remind them to follow these ABCs to keep their heart healthy:

A: Take aspirin for those at risk

B: Control blood pressure and have a blood pressure test done at least once a year (goal for 18–59 y.o. is <140/90 mmHg; goal for 60–85 y.o. with diabetes is <140/90 mmHg; goal for 60–85 y.o. without diabetes is <150/90 mmHg)

C: Manage cholesterol

S: Stop smoking

Also, be sure to prescribe cardiovascular drugs and smoking-cessation agents from Healthfirst's formulary. For a comprehensive list of medications, visit our website at **www.healthfirst.org/formulary**.

Family planning

Integrate preconception care, pregnancy intention, and contraceptive counseling into primary care visits.

At a minimum, initiate conversation about pregnancy intention, preconception care, and contraception at the annual visit and whenever new diagnoses or medications may be relevant to pregnancy risks or contraceptive method contraindications.

Consider using the *"One Key Question®"* approach:

Pose the question: *"Would you like to become pregnant in the next year?"*

- *For patients who answer "yes," offer preconception counseling and screenings to ensure that they are in optimal health for a pregnancy*
- *For patients who answer "no," counsel on the full range of contraception options to ensure that the method they use is optimal for their circumstances*
- *Patients who are ambivalent or unsure of their pregnancy intentions comprise a substantial portion of the population; offer these patients a combination of both services*

Discuss the relationship between patients' sexual and reproductive health goals, overall health and well-being, and contraception choices (e.g., medical conditions that affect pregnancy risk, potential drug interactions, contraceptive contraindications, side effects, etc.).

During primary care visits, when taking a medication history, include an inquiry about contraception and whether the patient is satisfied with their current contraceptive method.

If the patient is unhappy with their current contraceptive method, assess method concerns and recommend alternatives.

For adolescents, primary care visits should (at a minimum) include:

- Time alone with the provider
- Discussion about sexual activity, including STI and HIV prevention counseling as appropriate
- Contraception and pregnancy intention counseling and services

If the patient is unhappy with their current contraceptive method, assess method concerns and recommend alternatives.

Sources

www1.nyc.gov/assets/doh/downloads/pdf/ms/srh-clinical-guide.pdf;

www1.nyc.gov/site/doh/providers/health-topics/sexual-and-reproductive-health.page.

Prevention prior to and during pregnancy

Even if your pregnant patients take prevention measures, there is still a risk of having a child with a birth defect. However, following healthy habits early and often gives women the best chance to have healthy babies.

Prevention for Your Female Patients Planning to Have Children

- Schedule regular medical checkups
- Eat healthy foods and maintain a healthy weight
- Ensure that medical conditions, like diabetes, are under control
- Take a vitamin with folic acid every day
- Don't smoke, drink alcohol, or use street drugs
- Check with their health provider before taking **any** medications
- Avoid exposure to toxic secondhand smoke, chemicals, and fumes
- Test for infectious diseases and get necessary vaccinations
- Wash hands often to avoid getting sick
- Avoid changing/cleaning kitty litter boxes
- Avoid X-rays and other radiation

Postpartum care

Providers are reminded to document postpartum care in the medical record.

Postpartum visit to an OB/GYN practitioner or midwife, family practitioner, or other PCP on the 21st day, or between 21 and 56 days, after delivery.

Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and one of the following:

- Pelvic exam
- Evaluation of weight, BP, breasts, and abdomen
  - Notation of "breastfeeding" is acceptable for the "evaluation of breasts" component
- Notation of postpartum care, including, but not limited to:
  - Notation of "postpartum care," "PP care," "PP check," "six-week check"
  - A preprinted "Postpartum Care" form in which information was documented during the visit

Healthfirst encourages providers to file claims electronically using ICD-10 codes for postpartum visits. You may download the ICD-10 codes for postpartum visits at **www.healthfirst.org/hedis**.

Providers are reminded to document postpartum care in the medical record.

Well-child visits

Healthfirst is making every effort to engage our members in their healthcare, including getting their annual checkups before the end of the year. We are conducting outreach calls and Interactive Voice Response (automated) message campaigns, in addition to sending reminder letters, postcards, and emails to reinforce the importance of preventive services in keeping children healthy. Eligible members are also being offered a $25 reward card upon completion of their required childhood/adolescent immunizations as well as their six well-care visits for children age 0–15 months.

After our young members have completed their well-child visit, please submit claims and encounters with the following codes on a timely basis to ensure that you receive credit for the quality care you continuously provide:

HEDIS Requirements

Well-Child Visits 0–15 Months (W15)	Codes	
At least six well-child visits from birth through 15 months old	**CPT:** 99381–99385, 99391–99395, 99461 **HCPCS:** G0438, G0439	**ICD-10:** Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0–Z02.6, Z02.71, Z02.79, Z02.81–Z02.83, Z02.89, Z02.9
Well-Child Visits 3–6 (W34)		
At least one well-child visit annually for children 3–6 years old		
Adolescent Well Care (AWC)		
At least one well-child visit annually for adolescents 12–21 years old		

Continued on pg. 36

Well-child visits

Continued from pg. 35

In order to maintain the health and well-being of our pediatric members, below is the New York State Department of Health's (NYSDOH) recommended childhood and adolescent immunization schedule:

New York State Recommended Childhood and Adolescent Immunization Schedule

A check ✓ means that this is the earliest and best time for your child to be immunized. If your child misses the "best time" for vaccination, her or she should still be immunized as quickly as possible. Ask your doctor about getting your child caught up.

Vaccine	Birth	2 mths.	4 mths.	6 mths.	12 mths.	15 mths.	18–23 mths.	4–6 yrs.	11–12 yrs.	16 yrs.
Hepatitis B	✓	✓ 1–2 mo.		✓ 6–18 mo.						
Rotavirus		✓	✓	✓[1]						
Diphtheria, Tetanus, Pertussis (DTaP)		✓	✓	✓		✓ 15–18 mo.		✓		
Tetanus, Diphtheria, Pertussis (Tdap)[2]									✓[2]	
Haemophilus influenzae type b (Hib)		✓	✓	✓[1]	✓ 12–15 mo.					
Pneumococcal Disease (PCV)[3]		✓	✓	✓	✓ 12–15 mo.		Ask your doctor if your child 2 years old or older should get vaccinated with PPSV23.[3]			
Polio (IPV)		✓	✓	✓ 6–18 mo.				✓		
Influenza				Recommended yearly for all children age 6 months and older. Ask your doctor if your child should receive one or two doses.						

Vaccine	Birth	2 mths.	4 mths.	6 mths.	12 mths.	15 mths.	18–23 mths.	4–6 yrs.	11–12 yrs.	16 yrs.
Measles, Mumps, Rubella (MMR)[4]				See Fn. 4	✓ 12–15 mo.			✓		
Varicella (Chickenpox)					✓ 12–15 mo.			✓		
Hepatitis A					✓		✓			
Human Papillomavirus (HPV)[5]									✓[5]	
Meningococcal Disease [6]	Ask your doctor if your child 2 months old or older should get vaccinated against meningococcal disease.								✓	✓

For access to clinical tools, forms, and resources for use in your practice, please visit our website at **www.healthfirst.org/providers/provider-resources**.

[1]For some types of Hib and Rotavirus, the 6-month dose is not needed.

[2]Tdap: Children 7–10 years old who are not fully immunized against pertussis should receive a single dose of Tdap.

[3]PCV = Pneumococcal Conjugate Vaccine; PPSV23 = Pneumococcal Polysaccharide Vaccine.

[4]MMR: Children 6–11 months old who are traveling outside the U.S. should receive one dose of MMR before departure.

[5]The HPV vaccine is given through a series of three shots over a 6-month period. It is recommended for both boys and girls.

[6]There are two vaccines that protect against meningococcal disease. Some children with special medical conditions may need both MCV4 and MenB.

2378

This schedule is aligned with national guidelines set by the Advisory Committee on Immunization Practices and recommendations by the CDC.
New York State Department of Health 4/16

Oral Health

Optimal oral health for pregnant and postpartum women, infants, children, and adolescents can be achieved through an effective partnership among families, oral health professionals (e.g., dentists, dental hygienists), and other health professionals (e.g., physicians, physician assistants, nurse practitioners, nurses, dietitians). Health professionals need to help families understand the causes of oral disease, especially dental caries (tooth decay), and how to prevent or reduce oral disease and injury. By including prevention and early intervention as part of comprehensive oral health services, it may be possible to prevent or reduce future oral disease.

Resistance to tooth decay in pregnant and postpartum women, infants, children, and adolescents is determined partly by physiology and partly by behavior. The younger the child when tooth decay begins, the greater the risk for future decay. Because untreated tooth decay increases in severity, necessitating more extensive and costly treatment secondary to postponing care, timely intervention reduces overall cost associated with treatment. Preventing and/or delaying the onset of tooth decay may reduce the risk for decay.

The younger the child when tooth decay begins, the greater the risk for future decay. Because untreated tooth decay increases in severity, necessitating more extensive and costly treatment secondary to postponing care, timely intervention reduces overall cost associated with treatment.

The *Bright Futures in Practice: Oral Health—Pocket Guide (3rd ed.)* is designed to be a useful tool for health professionals—including dentists, dental hygienists, physicians, physician assistants, nurse practitioners, nurses, dietitians, and others—in addressing the oral health needs of pregnant and postpartum women, infants, children, and adolescents.

The pocket guide provides health professionals with an overview of preventive oral health supervision and includes information about risk assessment, a tooth-eruption chart, a dietary fluoride supplementation schedule, a glossary, and a list of resources.

Source:

www.mchoralhealth.org/pocket.php.

Compliance Corner

Healthfirst's Compliance and Privacy Program is designed to reduce or eliminate fraud, waste, abuse, and inefficiencies; to ensure Healthfirst's compliance with applicable regulations; and to reinforce Healthfirst's commitment to such activities.

Our goal is to provide you with important information and updates on compliance that are relevant to you. Compliance is an ever-changing environment, and the key to keeping up with those changes is communication. We always welcome feedback. You may email the Healthfirst Compliance, Privacy and Audit department at **compliance@healthfirst.org** with your thoughts, questions, or suggestions.

Update to the Notice of Privacy Practices

Healthfirst has recently made a change to its Notice of Privacy Practices. This change became effective as of August 2016.

The change details the different ways in which Personal Health Information (PHI) can be shared among the Healthfirst sponsor hospitals that are participating in the Healthfirst Health Information Exchange (HIE).

The notice can be reviewed at **www.healthfirst.org/privacy-notices**.

Provider Information Updates

As part of the reporting requirements we comply with regarding provider information (requirements mandated by governmental and regulatory authorities), and to provide the most up-to-date information on provider choices to our members, providers are responsible for contacting Healthfirst to report any changes in their practice. It is essential that Healthfirst maintain an accurate provider database in order to ensure proper payment of claims and capitation. Any changes and

updates to your provider record or participation with Healthfirst, including hospital affiliation, should be submitted to your Provider Representative at least 30 days prior to the effective date. Please use the list below as a guide to what should be reported to Healthfirst as an update.

These should be submitted with a sheet that includes full contact information and a comprehensive request on the provider or group letterhead that includes the provider's license number and identifies the practice record for update. Any supporting documentation (such as a W-9 form or a Board Certificate) should be included:

- Update in the provider or group name and tax ID number (W-9 required)
- Update in provider/group practice address, zip code, telephone, or fax number (full practice information required)
- Update in the provider/group billing address (W-9 required)
- Update in the member age limits for service at the practice (if applicable)
- Update in NY license, such as a new number, revocation, or suspension (new certificate or information on action required, if applicable)
- Closure of a provider panel (reason for panel closure)
- Update in hospital affiliation (copy of current and active hospital privileges)
- Update or addition of specialty (copy of board certificate or appropriate education information)
- Update in practicing office hours (PCPs need at least 16 hours)
- Update in provider's board eligibility/board certification status
- Update in participation status
- Update in NY Medicaid Number (if applicable)
- Update in National Provider Identification Number (if applicable)
- Update in wheelchair accessibility
- Update in covering provider
- Update in languages spoken in the provider's office

If you suspect a case of fraud, waste, abuse, or other violations of company policy, you can report it by calling the toll-free Confidential Compliance Hotline at **1-877-879-9137** or by filing a report via the confidential website address: **www.hfcompliance.ethicspoint.com**. Learn more at **www.healthfirst.org/providers/compliance**.

Providers are responsible for contacting Healthfirst to report any changes in their practice.

Network Updates

Clinical Practice Guidelines (CPG)

The 2016 Healthfirst Clinical Practice Guidelines (CPG) is available on our provider site at **www.healthfirst.org/providers/provider-resources**. This list of evidence-based peer review guidelines covers both routine and complex conditions.

Healthfirst Contracts with Change Healthcare®

As part of ongoing claim-review activities, Healthfirst has contracted with Change Healthcare, an independent company, to review the use of high-level Evaluation and Management (E/M) codes for all physicians participating in the provider network. The goal is to ensure that the appropriate E/M code and/or use of modifier 25 are billed for the clinical services provided to our members. Depending on your E/M and modifier 25 billing patterns, you may receive communications directly from Change Healthcare regarding E/M reviews. If you have questions regarding the reviews, contact Change Healthcare Customer Service at 1-844-592-7009, Option 3.

National Drug Code (NDC) Billing Requirements

Earlier this year, Healthfirst released guidance on National Drug Code (NDC) Billing Requirements. The prior guidance stated that all outpatient drug claims billed by providers who are not 340B qualified had to contain a NDC number. Failure to bill in this manner would result in denial of the drug line on a professional claim.

Effective December 15, 2016, a change in the policy for non-340B-qualified providers is set to occur. Failure to bill the NDC code by non-340B-qualified providers in an outpatient and/or professional setting will result in denial of all claims lines. If you encounter a denial, we encourage you to resubmit an electronic corrected claim. Corrected claim submissions will be subject to timely filing requirements, as set forth in your provider contract and provider manual.

Please note that the above policy change is applicable to all Healthfirst lines of business. Reference to the NDC billing requirements released can be located under the Claims and Billing section of the Healthfirst website.

For questions regarding this update, please contact Provider Services at **1-888-801-1660**, Monday to Friday 9am–5pm.

Healthfirst Now Offers Telemedicine Through Teladoc

Healthfirst members* now have 24/7 on-demand access to board-certified doctors who can diagnose, treat, and write prescriptions for a variety of non-emergent medical issues. This is a convenient option for members who are traveling, or as an alternative to urgent care and ER visits for minor conditions, and is not meant to replace a member's relationship with their primary care provider.

To learn more about this service, visit **www.healthfirst.org/alerts** to access our Teladoc FAQ for providers.

*Applies to members of Healthfirst Essential Plan, Healthfirst Leaf Premier plan, Healthfirst Pro EPO plan, Healthfirst Pro Plus EPO plan, and Healthfirst Total EPO plan.

Online Resources for Your Practice

www.HFprovidermanual.org	Review and download the most current Provider Manual.
www.healthfirst.org/providers	**Quick Reference Guides (QRGs)** for Medicaid, Commercial Plans, and Personal Care Agencies will help you to easily access valuable information.
www.healthfirst.org/alerts	Alerts and communications to make sure you have the information you need to offer our members top-quality care.
www.healthfirst.org/providerforms	Authorization and request forms in one location.
www.HFDocFinder.org	**Online provider directory** gives you and your patients detailed provider information—including weekend hours, office locations, and hospital affiliation—in an easy-to-use navigation. Review and update your provider profile and practice information.
www.HFDocEmails.org	Sign up for email updates on information you need as a provider in the Healthfirst network.

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