TheSource

Summer 2016

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, 9:00am–6:00pm

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

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

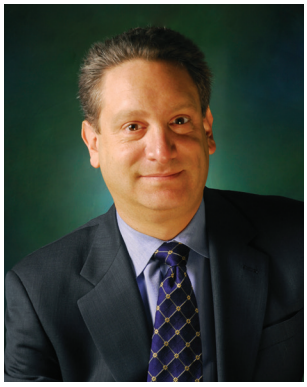
Member Services: Senior Health Partners
1-800-633-9717
Monday–Friday, 8:00am–8:00pm
Saturday, 10:00am–6:30pm

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 Summer edition of *The Source*, Healthfirst's quarterly news magazine, which delivers valuable information your practice can use to care for our members, stay up-to-date on key initiatives, and navigate claims and compliance issues.

I have some excellent news: Healthfirst was recently named the top-quality plan in New York State for our Medicaid plans. In light of the 5-star ratings for our Qualified Health and Medicaid Plans, and our 4-star rating for Medicare, this is an unprecedented accomplishment, made possible in part through close provider collaboration.

Is your practice prepared for the upcoming Medicare Health Outcomes Survey and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey? CMS uses these surveys to monitor and improve the quality of care for Medicare beneficiaries. Turn to page 26 of this issue to learn how you can influence both care quality and survey results.

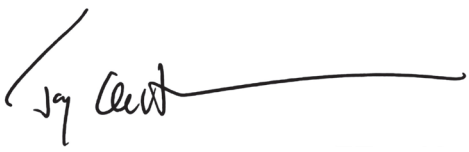
Among the measures used to determine quality is provider access and availability. Please turn to page 60 to learn about the standards we use to foster compliance with New York State regulations.

Members cannot access your practice if they cannot find your practice, or if the phone number or hours of operation on file is incorrect. To see how you can help keep your profile updated, turn to page 58.

As usual, this issue of *The Source* contains many other important stories, everything from tips that can improve your experience with our plan to formulary changes to educational articles on asthma, shortness of breath, and urinary incontinence/overactive bladder. 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**.

Frequently Asked Questions About Corrected Claims Submission

Failure to provide the original claim number on the corrected claim will result in the claim being rejected or denied as a duplicate.

What is a Corrected Claim?

A Corrected Claim is an electronic or paper claim that Healthfirst initially accepted but that has added and/or changed data elements which will potentially affect the payment of the claim. Below are some examples of data elements that may be changed:

- Diagnosis code
- Total charges or units billed
- Charge for dates of service not previously billed (late charges)
- CPT code
- Date of service/date span
- Member or provider
- Modifier
- Place of service (POS)
- Revenue code

What are the two ways to submit Corrected Claims?

Claims can be submitted through an Electronic Data Interchange (EDI) or by paper.

- EDI is the computer-to-computer transfer of business-to-business document transactions and information between trading partners. Many healthcare partners, payors, vendors, and fiscal intermediaries choose EDI as a fast, inexpensive, and safe method for automating business processes
- Paper claims can be submitted on the CMS-1500 (professional) and UB-04 (institutional) forms

When the corrected claim enters the Healthfirst claims system, the corrected claims process will use the **Original Claim Number** (which **must be provided** on the Corrected Claim, either on paper or submitted electronically) to find the original claim. **Failure to provide the original claim number on the corrected claim will result in the claim being rejected or denied as a duplicate.**

Additionally, corrected claims are processed as a **"new"** claim. Therefore, unless there are issues with the claim, payment can be expected within 30 days, in accordance with the Prompt Pay regulation.

How are EDI Corrected Claims different from Paper Corrected Claims?

EDI Corrected Claims: The electronic corrected claim has to be in a specific data file format and is submitted to Healthfirst electronically. When submitting an EDI "Corrected" Professional and/or Institutional claim to Healthfirst, the following data format must be followed:

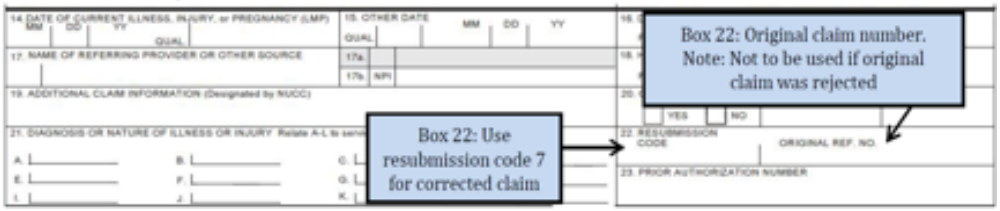
a. The type (CLM05-03) must be a 7.
Example: **CLM*8084*96.98***11>B>7*Y*A*W*I*P~**

b. The Healthfirst original claim ID must be sent in the REF*F8 segment in the 2300 loop. The Healthfirst claim ID is made up of a two-digit branch code, a six-digit batch date, a three-digit batch sequence, and a two-digit sequence ID. The Healthfirst claim ID can be found on the Explanation of Payment (EOP) and/or 835. Example: **REF*F8*9999999999999~**

Paper claims can be submitted on the CMS-1500 (professional) and UB-04 (institutional) forms.

CMS-1500 (Professional) should be submitted with the appropriate resubmission code (value of 7) in Box 22 of the paper claim with the original claim number of the corrected claim and a copy of the original EOP. EDI 837P data should be sent in the 2300 Loop, segment CLM05 (with value of 7), along with an addition loop in the 2300 loop, segment REF*F8* with the original claim number.

CMS-1500 Example *(please use red and white claim form for official submission)*



Continued on pg. 6

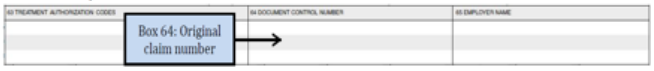
Frequently Asked Questions About

Corrected Claims Submission

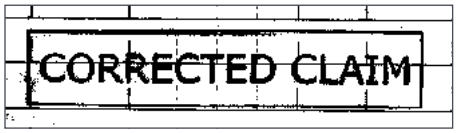
Continued from pg. 5

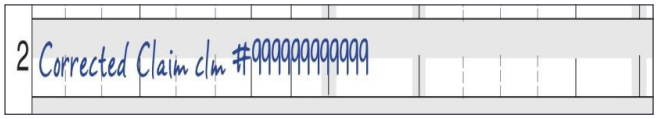
UB-04 (Institutional) should be submitted with the appropriate resubmission code in the third digit of the bill type (this will be 7), the original claim number in Box 64 of the paper claim, and a copy of the original EOP. EDI 837I data should be sent in the 2300 Loop, segment CLM05 (with value of 7), along with an addition loop in the 2300 loop, segment REF*F8* with the original claim number for which the corrected claim is being submitted.

UB-04 Example



Paper Corrected Claims must be marked "Corrected" and should be submitted within 180 days of the date of service. All Corrected Claims must include the original Healthfirst claim number being corrected.





What are the benefits of using EDI Corrected Claims vs. Paper Corrected Claims?

- Emdeon simplifies your claims management process by ensuring your claims are correct before being submitted
- Improves accuracy of information exchanged between healthcare participants
- Ensures fast, reliable, accurate, secure, and detailed information on patients and healthcare partner plans

How can I register for EDI claims submissions?

Providers who don't have claims submission software may sign up for an account with ABILITY to begin filing electronically at **www.abilitynetwork.com/** or at Emdeon claims clearinghouse: **www.emdeon.com/claims/**.

How do I enroll my office for electronic payments?

Contact your software vendor and request that your Healthfirst claims be submitted through Emdeon or have your current clearinghouse forward your claims to Emdeon.

Providers who don't have claims submission software may sign up for an account with ABILITY to begin filing electronically at **http://abilitynetwork.com/** or at Emdeon claims clearinghouse: **www.emdeon.com/claims/**.

Complete the following:

Emdeon ERA Provider Set-Up Form
http://assets.healthfirst.org/api/pdf?id=pdf_a6517d0e45&key=48fb1bff0f104fc66df28841333c06b3bb72dc25

Healthfirst EFT/ERA Authorization Form
http://assets.healthfirst.org/api/pdf?id=pdf_3cfa9e159d&key=d5c720d112b7851ec642fa8ee096d288a0bdd5c2

Healthfirst encourages providers to file online claims and accepts both institutional and professional claims this way.

Continued on pg. 8

Frequently Asked Questions About

Corrected Claims Submission

Continued from pg. 7

Include a voided check from the bank account in which you wish to deposit Healthfirst's electronic payments. Submit these documents to Healthfirst Provider Services in one of these three ways:

1. By fax: **1-646-313-4635**
2. By mail to:
   Healthfirst Provider Services
   P.O. Box 5168
   New York, NY 10274-5168
3. Give your completed paperwork to your Healthfirst Network Management representative.

How many claims should I send the first time I submit electronically?

It is recommended that a minimal amount of claims be sent for your first submission to ensure there are no issues with your claims. Should any issues arise, please contact your Network Administrator.

Any health plan that was selected by a Healthfirst member is authorized to submit claims.

Are there any restrictions on what products/lines of business (LOB) can submit a claim?

Any health plan that was selected by a Healthfirst member is authorized to submit claims.

Who can submit a Corrected Claim?

Providers both in and out of Healthfirst's network who have provided a service to a Healthfirst member can submit a claim either electronically (EDI) or by paper (manually).

When did EDI Corrected Claims submissions go into effect?

EDI Corrected Claims submissions became effective on June 1, 2016.

Why was my EDI claim rejected, and what do I need to do to correct it?

The following provides guidance based on the claim status category and code received, so that you may take the necessary action to submit the claim(s) for processing.

Claim Status Category	QA4	QA3	QA5	QA8
Claim Status Code	**A3**	**A3**	**A3**	**A3**
Claim Status Code Description	Submitted original claim ID is not valid	Original claim ID not supplied	Submitted original claim ID has already been adjusted	Submitted original claim ID has not been finalized; wait for remittance then resubmit on paper
Corrective Action	The claim number is incorrect; resubmit claim with a valid claim number	The original claim number must be provided when submitting a corrected claim	The original claim was already adjusted. If additional corrections are needed, indicate changes and resubmit on paper	Submitted original claim ID is not valid

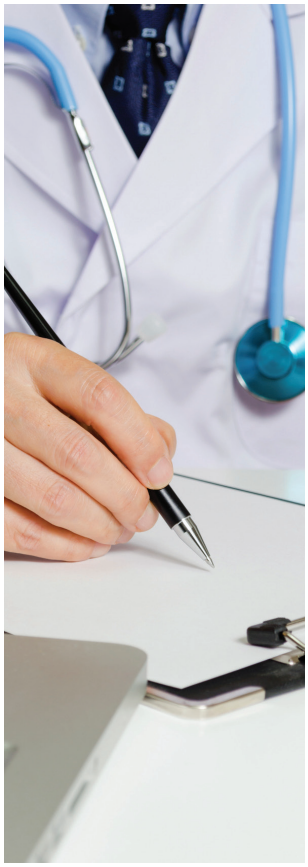
Continued on pg. 10

Frequently Asked Questions About

Corrected Claims Submission

Continued from pg. 9

Claim Status Category	**A7**	**A3**	**A3**
Claim Status Code	**464**	**78**	**54**
Claim Status Code Description	Payer assigned claim control number	Duplicate of an existing claim/line; awaiting processing	Duplicate of a previously processed claim/line
Corrective Action	The claim number is incorrect; resubmit claim with a valid claim number	Upon receipt of EOP, resubmit a corrected claim and provide the original claim number	The original claim was already adjusted. If additional corrections are needed, indicate changes and resubmit on paper



What should I do if my Corrected Claim was not filed in a timely manner or was denied?

A provider who submits a claim past the provider's timely filing agreement should consider requesting a Review and Reconsideration. At times, a provider may be dissatisfied with a decision made by Healthfirst regarding a claim determination. Some of the common reasons include, but are not limited to:

- incorrectly processed or denied claims;
- the untimely submission of claims;
- failure to obtain prior authorization.

Providers who are dissatisfied with a claim determination made by Healthfirst must submit a **written** request for review and reconsideration, with all supporting documentation, to Healthfirst within **ninety** (90) calendar days from the paid date on the provider's Explanation of Payment (EOP). Written requests, including attachments, are accepted via the Healthfirst provider website at **www.healthfirst.org** or addressed to the following location:

Healthfirst Correspondence Units

New York	Claims and Claims Correspondence	P.O. Box 958438 Lake Mary, FL 32795-8438	1-888-801-1660
	Provider Claim Appeals (2nd-Level)	P.O. Box 958431 Lake Mary, FL 32795-8431	N/A
Senior Health Partners	Claims and Claims Correspondence	P.O. Box 958439 Lake Mary, FL 32795-8439	1-877-737-2693
	Provider Claim Appeals (2nd-Level)	P.O. Box 958432 Lake Mary, FL 32795-8432	

All written requests for Review and Reconsideration via the provider website or P.O. Box 958438 should include the following information: a copy of the EOP, the claim, supporting documentation, and a written statement explaining why you disagree with Healthfirst's determination as to the amount or denial of payment.

Examples of information and supporting documentation that should be submitted with written requests for review and reconsideration include:

- A written statement explaining why you disagree with Healthfirst's claim determination
- Provider name, address, and telephone number
- Provider identification number
- Member name and Healthfirst identification number
- Date(s) of service
- Healthfirst claim number
- A copy of the original claim or corrected claim
- A copy of the Healthfirst EOP
- A copy of the EOP from another insurer or carrier (e.g., Medicare), along with supporting medical records to demonstrate medical necessity
- Contract rate sheet to support payment rate or fee schedule

Continued on pg. 12

Frequently Asked Questions About

Corrected Claims Submission

Continued from pg. 11

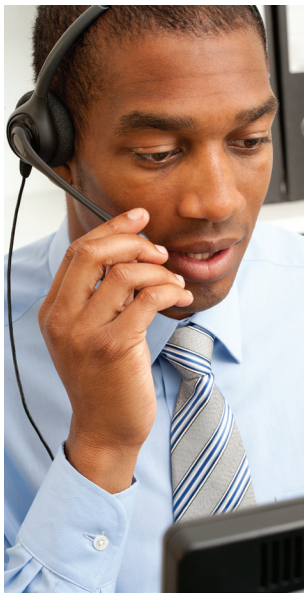
- Evidence of eligibility verification
- Evidence of timely filing:
  - RO59 Report (Insurance Carrier Rejection Report) or Emdeon Vision "Claim for Review"/"Claim Summary" Report
  - **Please note:** Healthfirst does not accept copies of certified mail or overnight mail receipts, or documentation from internal billing practice software, as proof of timely filing
  - Copy of the approval number issued by Medical Management

Healthfirst will investigate all written requests for Review and Reconsideration, and within thirty (30) calendar days from the date of receipt of the provider's request for Review and Reconsideration will issue a written explanation stating that the claim has either been reprocessed or that the initial denial has been upheld.

All questions concerning requests for review and reconsideration should be directed to Healthfirst **Provider Services** at **1-888-801-1660**.

Healthfirst will not review or reconsider claims determinations which are not appealed according to the procedures set forth above. If a provider submits a request for review and reconsideration after the ninety (90) calendar day time frame, the request is deemed ineligible and will be dismissed. Providers will not be paid for any services, irrespective of the merits of the underlying dispute, if the request for review and reconsideration is not timely filed. In such cases, providers may not bill members for services rendered.

All questions concerning requests for review and reconsideration should be directed to Healthfirst **Provider Services** at **1-888-801-1660**. There are no additional appeal rights if the original denial is upheld by Healthfirst; however, providers may file for arbitration pursuant to their provider agreement.



Are there other resources available?

Healthfirst Provider Website	Provider Alerts	**www.healthfirst.org/alerts**
	Claims & Billing	**www.healthfirst.org/providers/claims-billing**
	ICD-10 Tools & Information	**www.healthfirst.org/icd10**
	Provider Forms	**www.healthfirst.org/providerforms**
Healthfirst Provider Portal	Verify Member Eligibility	**www.healthfirst.org/providers**
	View Member Cost Sharing	
	Look Up Authorization	
	View Claims Status and Detail	
Provider Services	Provider Inquiries	**1-888-801-1660**
	Claims Inquiries	
Medical Management	Authorizations	**1-888-394-4327**
Ancillary Authorizations	CVS Caremark Specialty Pharmacy	**1-800-238-7828**
	CVS Caremark Pharmacy	**Medicaid: 1-877-433-7643**
		Medicare: 1-855-344-0930
		Commercial: 1-800-294-5979
	Davis Vision: Routine Vision Care/Glasses	**1-800-773-2847**
	Superior Vision: Surgical Procedures of the Eye	**1-888-273-2121**
	DentaQuest: Routine Dental Care	**1-888-308-2508**
	eviCore: Radiology	**1-877-773-6964**

Essential Plans 101

Have you heard of The Essential Plan?

In 2016, New York State launched a new program, called The Essential Plan, for low-income New Yorkers. This program offers quality, low-cost health insurance to thousands of hardworking New Yorkers. Many New Yorkers who are currently eligible for Medicaid or who receive subsidies for a Qualified Health Plan (QHP), such as a Healthfirst Leaf Plan, may be eligible to receive coverage through an Essential Plan. Essential Plan enrollment will be yearlong, as is the case with Medicaid enrollment.

Who is eligible for The Essential Plan?

To be eligible for an Essential Plan, your patients must be citizens or legal residents and earn between 138% (just over $16,000 yearly for an individual) and 200% (just over $23,000 yearly for an individual) of the federal poverty level, or they must be legal residents who have been in the United States for less than five years and earn less than 138% of the federal poverty level. Patients must also have no other source of insurance coverage, such as coverage through a spouse or their job.

This program offers quality, low-cost health insurance to thousands of hardworking New Yorkers.

What benefits do your patients receive as part of The Essential Plan?

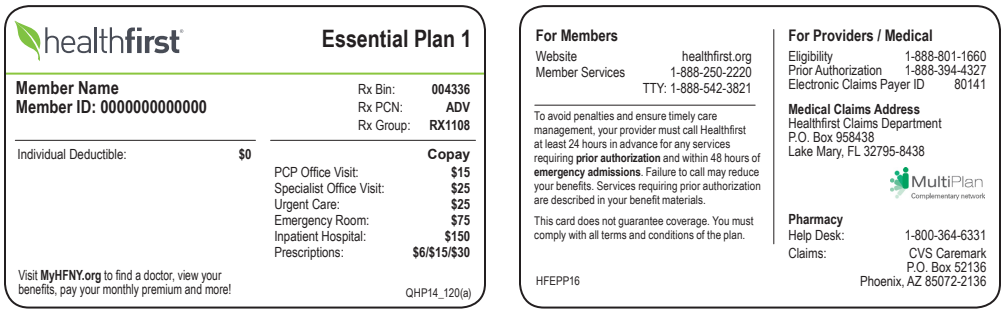
The Essential Plan offers the same benefits as Healthfirst's Leaf Plans. These include:

- Ambulatory Patient Services
- Emergency Services
- Hospitalization
- Mental Health and Substance Use Disorder Services Treatment
- Prescription Drugs
- Rehabilitative and Habilitative Services
- Laboratory Services
- Preventive, Wellness, and Chronic-Disease Management
- Maternity and Newborn Care (mothers must go to the NYSOH to report changes and gain coverage for newborn care)

Individuals will also be able to purchase vision and dental coverage. In addition, patients who have yet to meet the five-year residency requirement will continue to receive benefits such as non-emergency transportation, over-the-counter medication coverage, and vision and dental coverage. Under The Essential Plan, your patients will receive very affordable, comprehensive health coverage.

How is the Healthfirst Essential Plan different from Healthfirst Leaf Plans or Medicaid?

Healthfirst Essential Plan members have a different member ID number and card. A sample ID card is shown below:



healthfirst

Essential Plan 1

Member Name
Member ID: 0000000000000

Rx Bin: **004336**
Rx PCN: **ADV**
Rx Group: **RX1108**

Individual Deductible: **$0**

	Copay
PCP Office Visit:	$15
Specialist Office Visit:	$25
Urgent Care:	$25
Emergency Room:	$75
Inpatient Hospital:	$150
Prescriptions:	$6/$15/$30

Visit **MyHFNY.org** to find a doctor, view your benefits, pay your monthly premium and more!

QHP14_120(a)

For Members
Website healthfirst.org
Member Services 1-888-250-2220
TTY: 1-888-542-3821

To avoid penalties and ensure timely care management, your provider must call Healthfirst at least 24 hours in advance for any services requiring **prior authorization** and within 48 hours of **emergency admissions**. Failure to call may reduce your benefits. Services requiring prior authorization are described in your benefit materials.

This card does not guarantee coverage. You must comply with all terms and conditions of the plan.

HFEPP16

For Providers / Medical
Eligibility 1-888-801-1660
Prior Authorization 1-888-394-4327
Electronic Claims Payer ID 80141

Medical Claims Address
Healthfirst Claims Department
P.O. Box 958438
Lake Mary, FL 32795-8438

MultiPlan Complementary network

Pharmacy
Help Desk: 1-800-364-6331
Claims: CVS Caremark
P.O. Box 52136
Phoenix, AZ 85072-2136

The Healthfirst Essential Plan offers most of the same essential health benefits found in our Healthfirst Leaf Plans.

Unlike Healthfirst Leaf Plans, The Essential Plan does not require referrals. The Healthfirst Essential Plan offers most of the same essential health benefits found in our Healthfirst Leaf Plans.

Healthfirst Essential Plan eligibility is limited to adults; pediatric services are the only essential health benefit not covered under the Healthfirst Essential Plan.

There are additional benefits for legal residents who are ineligible for Medicaid due to immigration status (i.e., Aliessa Population) and who have incomes below $16,243 (Essential Plan 3 and Essential Plan 4). These benefits are:

- Non-Emergency Transportation
- Non-Prescription Drugs
- Orthotic Devices, Orthopedic Footwear
- Adult Vision Care
- Adult Dental Care

The Healthfirst Essential Plan does not include Personal Care Assistance benefits.

How much does The Essential Plan cost?

Monthly premiums for The Essential Plan will be either $0 or $20, depending on income. There is also an option to add dental and vision coverage for a few dollars more.

You may download our Provider Quick Reference Guide on The Essential Plan at **www.healthfirst.org/providers**.

How to Verify a Member's Eligibility

There are several ways for you to verify a member's eligibility. Note that member eligibility may change from time to time, including retroactively in certain circumstances. Verification of eligibility, therefore, does not ensure subsequent claims payment.

Note that verification of eligibility at the time of service does not guarantee payment by Healthfirst. Claims must still be submitted in a timely manner with all required information. In addition, members may lose eligibility after services are provided and claims are submitted. What's more, the loss of eligibility may be retroactive to the date of service.

Medicaid, Managed Care, and Medicaid identification cards together, since some benefits can be accessed only through the Medicaid card.

Claims must still be submitted in a timely manner with all required information.

To ensure coverage is renewed, please remind your Healthfirst members to call us 60 days prior to their coverage expiration date so we can assist them with their renewal. Providers must use one of the following steps to verify a member's eligibility before or at the time of service.

View the Member ID Card

Each Healthfirst member is issued an identification card that includes the member's plan name and Primary Care Physician (PCP), as well as other identification and informational items. If a Healthfirst member is eligible for dental coverage, the dental phone number will be printed on the member ID card. Medicaid members should keep their Healthfirst Leaf Plan and Leaf Premier Plan member ID cards will indicate the member's plan deductible limit and their cost-sharing/copayment responsibilities. Leaf and Leaf Premier Plan member ID cards will also carry the member portal site, **www.myHFNY.org**. Leaf and Leaf Premier Plan members can be referred to the portal to pay their plan premium, find a doctor, access more information on their plan benefits, and more.

Verify Online (www.healthfirst.org/providers)

Providers can use the member's Healthfirst ID number to access eligibility information on our website. Providers can verify eligibility for up to ten members at one time or view individual information and demographics.

Check the Member Enrollment Roster

Members are enrolled monthly into the Healthfirst plans. Members select a PCP at the time of enrollment. Healthfirst provides PCPs a monthly enrollment roster that identifies new members in the provider's panel as well as those members who have left the practice. The enrollment roster contains demographic information for each member by Healthfirst plan. Providers may use these rosters to verify eligibility. However, if a member is not listed on the roster and says that he/she belongs to the provider's panel, the provider should verify eligibility through the Member Eligibility section of our website or by calling Member Services. Member Enrollment Rosters are available on the Healthfirst secure provider portal.

Check eMedNY

Codes:

- **Code SF** to verify enrollment in the Healthfirst Medicaid plan
- **Code Y8** to verify enrollment in the Healthfirst Medicare plan
- **Code MH** to verify enrollment in the Healthfirst Medicare/Medicaid with Long Term Care benefits for CompleteCare (CC) Plan

Healthfirst provides PCPs a monthly enrollment roster that identifies new members in the provider's panel as well as those members who have left the practice.

In some cases, a member may be added to a provider's panel after the monthly enrollment roster is created. If there is a discrepancy between the roster, the member's identification card, and the eMedNY system, or if there are questions about a member's eligibility, please call Member Services for the most current information.

Commercial Plans

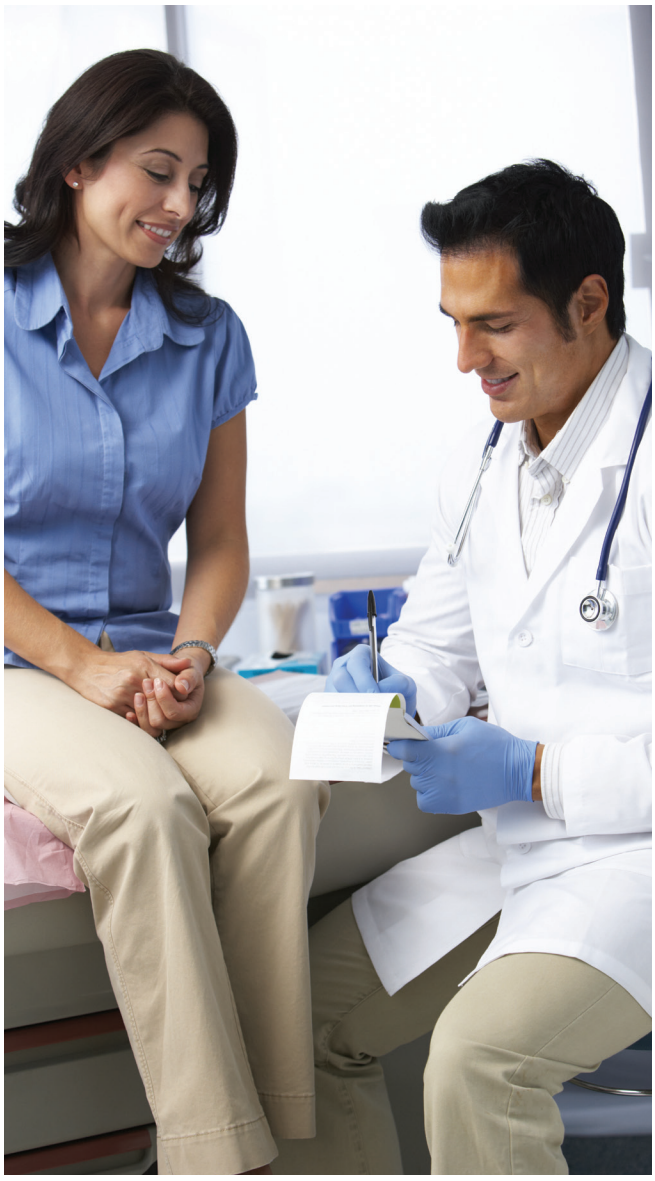
Members in Healthfirst Leaf and Leaf Premier Plans or HMO A-D plans may have monthly premium responsibilities. Members with premium obligations will have to pay their premiums on time in order to maintain their insurance coverage. Members who receive no federal subsidies will have a 30-day grace period in which to pay their premiums. Members who receive federal subsidies will have a 90-day grace period to pay their premium. If members fail to pay their premium at the end of their grace period, they will be disenrolled. Claims incurred by members in the first 30 days of a 90-day grace period will be paid; those incurred in days 31–90 will not be paid unless the member pays their premium before the end of their grace period. To verify a member's eligibility in the commercial plan, providers can:

- Call Provider Services at **1-888-801-1660**
- Log on to the provider portal, **www.healthfirst.org/providers**

You Can Help Healthfirst

Eliminate Care Gaps

Reducing gaps in patient care is an important part of quality improvement. Find out how you can help ensure your patients are getting the care they need.



Helping your patients get their recommended services is a long-standing priority for both you and Healthfirst. However, it's not always clear which Healthfirst members have missed recommended care.

To address this challenge, Healthfirst has teamed up with Inovalon to identify members who've missed services, based on their claims data and patient profile. Inovalon mails the member a letter encouraging them to schedule an appointment and specifying which services are needed. In some cases, the patient may receive a home visit from a nurse practitioner or be asked to visit an Inovalon-run clinic.

However, closing care gaps often takes more than a letter to a patient—and that's where you come in. If you get a letter from Inovalon about patients who've missed recommended care, you can help by calling the member to remind them about their recommended services and telling them why these services are important.

Your letter from Inovalon might also ask for additional information about a patient, such as a diagnosis. If so, please provide the requested details through the Inovalon portal at **https://epass.inovalon.com** (registration is required) or by fax at **1-866-682-6680**. Thanks for helping Healthfirst close gaps in member care.

Health Outcome Survey (HOS) Measures Impact Medicare Star Ratings

Based on the activity levels reported by your patient, you may recommend that they start, increase, or maintain their level of exercise or physical activity.

Key Conversations To Have With Your Medicare Patients

During a Medicare patient's primary care visit, it is important to ask the patient about their overall physical well-being. It is especially important to assess and ask Medicare patients about their physical activity, risk for falling, and any issues with bladder control, as these may not be topics patients bring up to physicians themselves.

Physical Activity
Ask your patients about their lifestyle and physical activities to assess if they are getting enough physical activity. Based on the activity levels reported by your patient, you may recommend that they start, increase, or maintain their level of exercise or physical activity. You may ask them to start taking the stairs, increase walking from 10 to 20 minutes every day, or maintain their current exercise routine.

Fall Risk
Assess your patients' risk of falling by asking:

- Have you fallen in the past year?
- Have you had any problems with balancing or walking?
- Do you feel unsteady when standing or walking without a support, like a cane?

Patients who've had a fall or problems with balancing or walking may be at risk of falling or injuring themselves again. You should identify whether your patients are at risk, discuss appropriate interventions to reduce this risk, and provide treatment. You may also recommend that they participate in physical therapy, have a vision or hearing test, or use a cane or walker.

Bladder Control
Ask your patients if they've experienced any problems with urinary incontinence, and discuss appropriate treatment.

Having these discussions and interventions helps keep our members safe and healthy.

Is Long-Term Care Right for Your Patient?

Patients with chronic illnesses or disabilities often have trouble performing activities of daily living (ADLs), such as bathing, dressing, and using the bathroom. Long-term care helps these patients maintain their independence while ensuring their dietary, hygienic, and other health needs are met. If any of your patients require 120 or more days of long-term care services, can live safely at home, and meet certain eligibility requirements, a Healthfirst long-term care plan may be right for them.

What are the benefits of Healthfirst's long-term care plans?

Healthfirst's long-term care plans give patients access to a comprehensive care management team that includes a primary care physician, a nurse, a social worker, and a support coordinator. The AbsoluteCare FIDA plan also covers behavioral health services and allows for a behavioral health professional to be a part of care management team. In addition to ADLs, the care management team can provide routine in-home medical care such as injections, speech and physical therapy, and more.

What long-term care plans does Healthfirst offer?

Senior Health Partners (MLTC Plan)

- A Managed Long Term Care Plan that gives patients access to community-based long-term care services such as home health and nursing home care
- This may be an option if the patient already has health coverage—like fee-for-service Medicaid or another Medicare Advantage plan—that doesn't include long-term care services

Healthfirst CompleteCare (HMO SNP)

- An all-in-one plan that provides the patient with health coverage and gives access to community-based long-term care services or to residence in a nursing home

Healthfirst AbsoluteCare FIDA Plan (Medicare-Medicaid Plan)

- A plan for beneficiaries who have both Medicare and Medicaid and who require community-based long-term care services or reside in a nursing home

2016
Healthfirst Long-Term Care Plans

	CompleteCare	AbsoluteCare FIDA	Senior Health Partners
Care and service team	✓	✓	✓
Vision care	✓	✓	✓
Dental care	✓	✓	✓
Home-delivered meals	✓	✓	✓
Nursing home care	✓	✓	✓
Personal care	✓	✓	✓
Physical, occupational, and speech therapies	✓	✓	✓
Medical equipment and supplies	✓	✓	✓
Home health aide services	✓	✓	✓
Respiratory therapy	✓	✓	✓
Social day center or adult day health center	✓	✓	✓
Transportation to your doctor or day center	✓	✓	✓
Audiology, hearing aids, and batteries	✓	✓	✓
Personal Emergency Response System (PERS)	✓	✓	✓
In-home nursing visits	✓	✓	✓
Podiatry and routine foot care	✓	✓	✓
Nutritional supplements	✓	✓	✓
Social services	✓	✓	✓
Primary doctor and specialist office visits	✓	✓	
Inpatient and outpatient care	✓	✓	
Medicare Part D prescription drugs	✓	✓	
Get $480 per year ($40/month) for over-the-counter items	✓		
Acupuncture	✓		
Enhanced behavioral health services		✓	

Continued on pg. 22

Is Long-Term Care Right for Your Patient?

Continued from pg. 21

What are the eligibility requirements?

Senior Health Partners (MLTC Plan)

- Be age 21 or over
- Live in the Bronx, Brooklyn, Manhattan, Queens, or Staten Island, or in Nassau or Westchester county
- Have Medicaid benefits or be willing to pay privately. Private pay enrollment is limited and does not apply to Nassau, Richmond, or Westchester county residents

Healthfirst CompleteCare (HMO SNP)

- Be age 18 or over
- Live in the Bronx, Brooklyn, Manhattan, Queens, or Staten Island, or in Nassau county
- Have Medicare Parts A and B
- Receive full New York State Medicaid benefits or be willing to apply

Healthfirst AbsoluteCare FIDA Plan (Medicare-Medicaid Plan)

- Be age 21 or over at the time of enrollment
- Live in the Bronx, Brooklyn, Manhattan, Queens, or Staten Island, or in Nassau or Westchester county
- Be entitled to Medicare Part A, enrolled in Medicare Part B, and eligible to enroll in Part D, and receiving full Medicaid benefits
- Be expected to need long-term care services for more than 120 days (some exclusions apply)

How much will a patient pay?

Patients pay nothing for covered services with Senior Health Partners, CompleteCare, or AbsoluteCare. If they are eligible for Medicaid with a spend-down, they pay the monthly spend-down amount to the plan providing their long-term care coverage. If they are not eligible for Medicaid and would like to join Senior Health Partners, they must pay a private premium.

How can I learn more?

To learn more about Healthfirst's long-term care offerings, contact Provider Services at **1-888-801-1660**, Monday to Friday, 8:30am–5:30pm.

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 two 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 community office, 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. 24

My Patients Are Turning 65.

What Are Their Options?

Continued from pg. 23

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 and/or distribute 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–Friday, 9am to 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.

My Advocate will ask your patients questions about their finances to determine which programs they might be eligible to receive.

Frequently Asked Questions About CAHPS

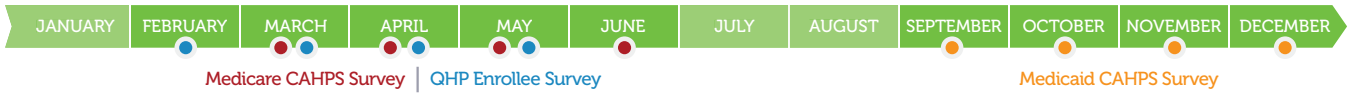
What are the CAHPS surveys?

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask patients to evaluate their experiences with healthcare, including their providers.

When are the surveys conducted?

The surveys are conducted annually for our Medicare, Medicaid, and Qualified Health Plans (QHP) members through a certified vendor on behalf of the Centers for Medicare & Medicaid Services (CMS) and the New York State Department of Health.

Healthfirst also conducts CAHPS-like satisfaction surveys year-round to understand what drives patient satisfaction.



What are the topics covered in the CAHPS survey?

The 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.

What type of questions are patients asked to evaluate their experience with care?

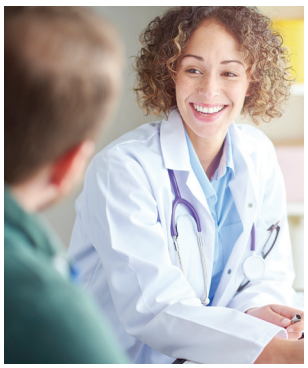
We have highlighted questions for each of the key topics in the grid on the following page. These measures are subject to change each year and may vary across each survey.

Getting Needed Care	■ In the last 6 months, how often was it easy to get appointments with specialists? ■ In the last 6 months, how often was it easy to get the care, tests, or treatment you needed through your health plan?
Getting Care Quickly	■ In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? ■ In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed? ■ Wait time includes time spent in the waiting room and exam room. In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?
Coordination of Care	■ In the last 6 months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care? ■ In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results? ■ In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did you get those results as soon as you needed them? ■ In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking? ■ In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services? ■ In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?

Why is improving patient satisfaction important?

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.



Continued on pg. 28

Frequently Asked Questions About

CAHPS

Continued from pg. 27

Healthfirst has collected and developed resources to help you understand different approaches to improving the patient experience in your practice.

What drives the patient satisfaction measures?

Some root causes of dissatisfaction are appointment availability, long wait times, and overcrowding.

How can I improve patient satisfaction in my practice?

Some examples of interventions that have proved to be useful include:

- Offering same-day appointment options and extended hours
- Placing large monitors near work stations to assess wait times more efficiently
- Utilizing specialized visit types and extended appointment lengths
- Daily auditing of next available appointment and active use of cancellation and wait lists
- Setting expectations for when you will follow up with the patient's test results

Where can I find additional information on improving patient satisfaction?

Healthfirst has collected and developed resources to help you understand different approaches to improving the patient experience in your practice.

You may 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 patients.

Voice of the Patient/Member

What do patients want? Recent studies have shown that patients value convenience over credentials[1]. Patients want to be seen in a time that accommodates their work schedule and when they feel they want to be seen, regardless of whether their symptoms are medically urgent.

At Healthfirst, we have gathered feedback around what drives our members to rate their experience poorly on the satisfaction surveys:

- *"I am fighting with them saying come in in three months. In three months, I will be dead."*
- *"Sometimes, I have to wait at least a month to get an appointment. I would rather not go to the doctor, and I get sicker."*
- *"I have to see them when they want to see me and not when I want to see them."*
- *"The doctor gave me an appointment that was very far away. I needed an appointment sooner, so I had to go to a different doctor."*
- *"To meet with my primary doctor, I have to make an appointment a month in advance."*

During the visit/wait times:

- *"Overcrowding, there were too many patients."*
- *"They filled too many people in for the same time."*
- *"The doctor was running late."*
- *"Registration takes about 20 minutes."*

Coordination of care/follow-up care:

- *"They never respond back to me or call back."*
- *"The specialist says to leave a message and doesn't call back and follow up."*
- *"The pain is awful, but they didn't give me medicines to help."*
- *"I am still waiting on my pills because the doctor still has not called the refill in. I had to buy over-the-counter medicine just so that I could have my medication."*

[1]www.advisory.com/~/media/Advisory-com/Research/MPLC/Resources/2015/30502_MPLC_Consumer_Survery_IG_web.pdf

Continued on pg. 30

Voice of the Patient/Member

Continued from pg. 29

Best Practices to Improve Access to Care/Patient Satisfaction

- Same-day PCP appointment (acute conditions)
- 3-day PCP appointment (any condition)
- 10-day specialist appointment
- Daily auditing of next available appointment and active use of cancellation and wait lists
- Offer extended hours of operation (early morning, evening, and weekend hours)

Standardize and enhance scheduling methods:

- Increase length of visits and create highly specialized appointment types. Having your appointment reflect the actual time it takes to complete the visit will allow you to better balance your schedule and understand where access barriers exist
- Review your schedule daily to identify where appointment slots can be created when your next-available is further out than 1–2 weeks
- Offer alternative options. Patients want choices that meet their personal preferences. If you are unable to accommodate, refer them to a colleague or to someone else on your team who can meet their needs
- Offer same-day/open-access scheduling options
- Actively monitor wait list/cancellation list and proactively move patients up sooner
- Offer self-scheduling through an online portal
- Conduct auto or live person confirmation calls to avoid no-shows and identify cancellations early that can free up slots for patients who want to be seen sooner

Improve wait times:

- **Waiting room rounding and logging:** Set a consistent schedule to survey the waiting areas and check in with patients. They will appreciate the engagement, and this will help you identify any issues that arise or avoid prolonged waits
- **Set expectations:** Patients will appreciate when you provide them a realistic pulse of how long they will have to wait or if there is a delay. Proactively informing them can have a better impact on satisfaction than leaving someone to wait without any idea of when they will be seen
- **Offer online pre-registration portals or in-office self-registration:** This can reduce the amount of time spent during a visit
- **Provide snacks and light refreshments/offer waiting room activities (e.g., magazines or television):** If wait can't be avoided, provide patients something to occupy them and to make them feel welcome and cared for during their wait
- **Place large monitors near work stations to display patient arrival and visit status:** Having indicators present to everyone will help your team identify how to improve patient flow throughout the day and allow you to take action should anyone be waiting longer than expected

Referral approaches:

- Avoid referring patients to an out-of-network provider
- Facilitate specialist, testing, and treatment appointment scheduling for the patient instead of giving them the contact information at check out to do themselves
- Ensure your patients are aware of any practice sites that do not accept Healthfirst

Best Practices to Improve Coordination of Care

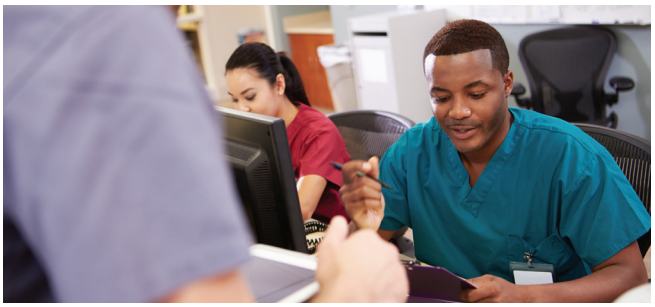
Test results:

- Let your patients know when they will receive their test results

Proactive medical-records gathering:

- Obtain records at the point of scheduling and send records out when referring to another provider
- Use Auto-Fax and other EMR functions to receive and send out records
- Obtain all external provider contact information and add it to the patient's chart at the point of scheduling and after the initial visit
- Identify a patient navigator to follow up with all care and results after the visit
- Make medical records available via a patient portal and encourage patient use for obtaining records

Patient satisfaction has been linked to improved health outcomes.
Studies have shown that the ability to access care in a timely manner results in reduced healthcare disparities, improved management of chronic conditions, and increased rates of patients receiving preventive care.[2]



Why is patient satisfaction important to your practice?
Excellent customer service provided by your office team, and empathy and engagement around your patients' health goals, are essential to maintaining a successful relationship with your patients. At Healthfirst, we consider the satisfaction of members with their patient experience to be integral to quality.

Improving patient satisfaction may benefit your practice and increase revenue:

- Patients are more likely to return for their follow-up care and refer the provider to friends and family
- Offering appointments in a timely manner may reduce "no-shows"
- For providers participating in the Healthfirst Quality Incentive Program, improving patient satisfaction may increase the payments earned for your practice

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 patients.

[2]A. C. Beal, M. M. Doty, S. E. Hernandez, K. K. Shea, and K. Davis, Closing the Divide: How Medical Homes Promote Equity in Health Care—Results from the Commonwealth Fund 2006 Health Care Quality Survey, The Commonwealth Fund, June 2007.

Appointment Availability and 24-Hour Access Standards

Healthfirst maintains provider access, visit scheduling, and waiting time standards that comply with New York State (NYS) regulations. Healthfirst and the New York State Department of Health (NYSDOH) actively monitor adherence to these standards. Healthfirst conducts audits of provider appointment availability, office waiting times, and 24-hour access and coverage. All participating providers are expected to provide care for their Healthfirst patients within these access guidelines.

This chart highlights the NYS standard timeframes for access and availability. It is required that you at least meet these standards. If you want to improve member satisfaction and provide an excellent patient experience, you should aim to exceed the standards and accommodate the patient's preferences.

Healthfirst conducts audits of provider appointment availability, office waiting times, and 24-hour access and coverage.

Type of Service	Standard(s)
Emergency Care: An emergency condition is defined as a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in placing the health of the person afflicted with such condition in: **a)** serious jeopardy, impairment, dysfunction, disfigurement, or **b)** placing the health of others in serious jeopardy, in the case of a behavioral condition.	Care must be provided **immediately** upon presentation at the service delivery site.
Urgent Care: Urgent care services are healthcare services that are not emergency services (as that term is defined in the applicable plan contract). These services are provided for an unexpected illness, injury, or condition which a reasonable person would believe requires immediate medical attention.	Urgent medical or behavioral problems must be seen to within **24 hours** of request.
Non-urgent "Sick" Visits: These are visits for symptomatic conditions that are neither of an emergent nor an urgent nature.	Visit must be scheduled within **48 to 72** hours of request as indicated by the nature of the clinical problem.
Routine Care: These visits are for routine management of clinical conditions or other follow-up care, as is clinically appropriate.	Appointment must be scheduled within **4 weeks** of request.
Adult Baseline and Routine Physicals	Appointment must be scheduled within **12 weeks** of enrollment.
Well-Child Care Visits	Appointment must be scheduled within **4 weeks** of request.

Continued on pg. 34

Appointment Availability and 24-Hour Access Standards

Continued from pg. 33

Type of Service	Standard(s)
Initial Prenatal Visits	**First Trimester:** Appointment must be scheduled within **3 weeks** of request. **Second Trimester:** Appointment must be scheduled within **2 weeks** of request. **Third Trimester:** Appointment must be scheduled within **1 week** of request.
Newborn Visits: Initial Visit to the PCP	Appointment must be scheduled within **2 weeks** of hospital discharge.
Initial Family Planning Visits	Appointment must be scheduled within **2 weeks** of request.
Non-urgent Referred Specialist Visits	Appointment must be scheduled within **4 to 6 weeks** of request.
In-Plan Behavioral Health or Substance Abuse Follow-up Visits (subsequent to an emergency or inpatient stay)	Appointment must be scheduled within **5 days** or as clinically indicated.
In-Plan Non-urgent Behavioral Health or Substance Abuse Visits	Appointment must be scheduled within **2 weeks** of request.

Office Hours

Each Medicaid, managed care, and CHPlus PCP must practice at least two (2) days per week and maintain a minimum of 16 office hours per week at each primary care site. HIV Specialist PCPs working at academic institutions may have some flexibility with this requirement. Medicare and commercial providers must maintain a minimum of ten (10) office hours per week at each primary care site. Providers who care for the homeless population are not required to maintain a minimum of 16 office hours per week at each primary care site.

24-Hour Coverage

Participating providers must be accessible 24 hours a day, 7 days a week, throughout the year, either directly or through backup coverage arrangements with other Healthfirst participating providers. Each provider must have an on-call coverage plan, acceptable to Healthfirst, that outlines the following information:

- Regular office hours, including days, times, and locations
- After-hours telephone number and type of service covering the telephone line (e.g., answering service)
- Providers who will be taking after-hours calls

Facilities as well as individual practitioners must conform to the following requirements:

- Members will be provided with a telephone number to use for contacting providers after regular business hours. Telephone operators receiving after-hours calls will be familiar with Healthfirst and its emergency care policies and procedures and will have key Healthfirst telephone numbers available at all times
- The Healthfirst provider will be contacted and patched directly through to the member, or the provider will be paged and will return the call to the member as soon as possible, but in no case to exceed 30 minutes

Medicare and commercial providers must maintain a minimum of ten (10) hours per week at each primary care site. Providers who care for the homeless population are not required to maintain a minimum of 16 office hours per week at each primary care site.

Continued on pg. 36

Appointment Availability and 24-Hour Access Standards

Continued from pg. 35

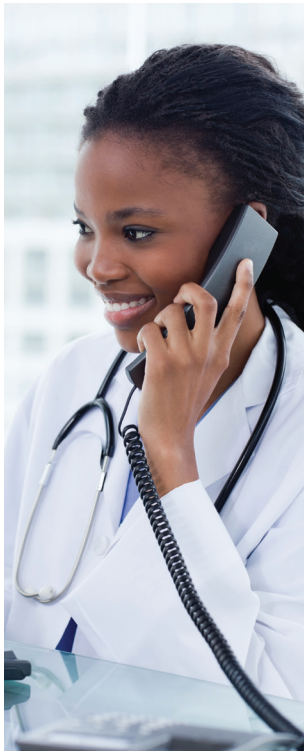
- It is expected that Healthfirst providers will be familiar with Healthfirst and will be able to act in accordance with Healthfirst emergency policies and procedures such as notifying Medical Management of emergency care or admissions. These policies are further discussed in Section 11 of the Provider Manual. Please be aware that hospital-based providers may have their own particular on-call group relationships
- If the covering provider is not located at the usual site of care for the member, the covering provider must provide clinical information to the member's PCP by the close of business that day, or, if on a weekend, by the next business day, so that it can be entered into the member's medical record

Healthfirst members must be able to locate a Healthfirst participating provider or his/her designated covering provider. It is not acceptable to have an outgoing answering machine message that directs members to the emergency room in lieu of appropriate contact with the provider or covering provider. If an answering machine message refers a member to a second phone number, a live voice must answer that phone line.

Waiting Time Standards

In addition to access and scheduling standards, Healthfirst providers are expected to adhere to site-of-care waiting time standards. They are as follows:

- **Emergency Visits:** Members are to be seen immediately upon presentation at the service delivery site
- **Urgent Care and Urgent Walk-in Visits:** Members should be seen within one (1) hour of arrival. Please note that prescription refill requests for medications to treat chronic conditions are considered urgent care. It is essential that these medications be dispensed to members promptly to avoid any lapse in treatment with prescribed pharmaceuticals
- **Scheduled Appointments:** Members should not be kept waiting for longer than one (1) hour. *CAHPS Standard: Members rate you on whether they are waiting longer than 15 minutes of their scheduled appointment time to see their provider
- **Non-urgent Walk-in Visits:** Members with non-urgent care needs should be seen within two (2) hours of arrival or scheduled for an appointment in a timeframe consistent with the Healthfirst scheduling guidelines



Healthfirst members must be able to locate a Healthfirst participating provider or his/her designated covering provider.

Missed Appointments

Healthfirst expects providers to follow up with members who miss scheduled appointments. When there is a missed appointment, providers should follow the guidelines below to ensure that members receive assistance and that compliance with scheduled visits and treatments is maintained:

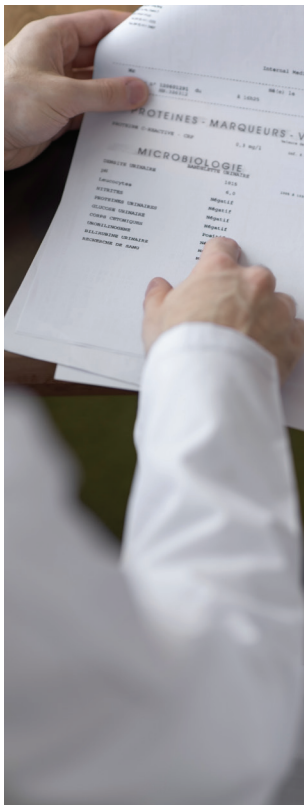
- At the time an appointment is scheduled, confirm a contact telephone number with the member. If the member does not keep the scheduled appointment, document the occurrence in the member's medical record and attempt to contact the member by telephone
- To encourage member compliance and minimize the occurrence of "no-shows," provide a return appointment card to each member for the next scheduled appointment

Test Results and Medical Records

- When you refer Healthfirst members for tests and treatments, be sure to discuss when the results will be available and the procedure for following up with test results
- Give your Healthfirst members a clear timeframe of when they should follow up to review results with you
- Notify Healthfirst members of both **normal and abnormal** test results. In the event of delayed results, contact your Healthfirst members to inform them of the status of their testing
- Make sure you have updated contact information (name, address, phone, etc.) for your Healthfirst members
- Assist your Healthfirst members with securing their medical records from past providers. Their care will be improved when your medical team has their full medical history

You should educate your patients on all these standards and define their expectations so they understand that the care they are receiving is timely and optimal based on their condition. Your office policies and workflows should aim to go above and beyond the standards listed in this article.

Give your Healthfirst members a clear timeframe of when they should follow up to review results with you.



Clinical Partnerships

Reducing Disparities in Care for High-Risk Postpartum Women

An innovative partnership among Healthfirst, the Icahn School of Medicine at Mount Sinai, and The New York Academy of Medicine aims to improve care for low-income, postpartum patients in New York City. Childbirth is the number one reason for a hospital admission, and postpartum care offers an opportunity to impact the current and future health of vulnerable women. Racial and ethnic disparities in maternal health outcomes are striking. Compared to non-Hispanic white women, black and Hispanic/Latina women experience greater maternal mortality, life-threatening morbidities, and pregnancy complications, as well as the onset of chronic illnesses such as hypertension and diabetes. Many low-income women of color with hypertension or diabetes fail to get appropriate medical follow-up postpartum, putting their long-term health at risk. In addition, these chronic health conditions are a leading cause of postpartum hospital readmissions. Postpartum care is important for monitoring the health of women with chronic illness and as a means to connect vulnerable women with the healthcare system. Yet rates for postpartum visits are low, particularly for underserved women (55–60%).

Postpartum care is important for monitoring the health of women with chronic illness and as a means to connect vulnerable women with the healthcare system.

Currently, a project that aims to improve care for postpartum women is being funded by a $500,000 grant from the Robert Wood Johnson Foundation. The lead investigator for the project, titled "Reducing Disparities in Care for High-Risk Postpartum Women Through Redesign of Payment and Delivery Systems," is Elizabeth A. Howell, MD, MPP, Vice Chair of Research, Department of Obstetrics, Gynecology, and Reproductive Science, Mount Sinai Health System, Associate Professor of Population Health Science and Policy, and Associate Professor of Obstetrics, Gynecology and Reproductive Science at the Icahn School of Medicine at Mount Sinai. "Our project aims to improve quality of care for high-risk postpartum patients by combining a social work-case management intervention with a new payment system designed to incentivize clinicians," said Dr. Howell. "By intervening at the earliest possible stage, we hope to improve health outcomes and minimize or prevent the consequences of costly chronic health conditions."

This behavioral education intervention prepares and educates women about gestational diabetes, hypertension, and depression; bolsters support; supports self-management; increases access to community resources; and reduces barriers to follow-up care. The purpose of this study is to reduce disparities and improve quality of care for Healthfirst postpartum patients by increasing rates of timely postpartum visits, by reducing postpartum emergency room visits and hospitalizations, and by reducing postpartum depressive symptoms. The intervention is coupled with a payment reform initiative to align incentives and appropriate care. The target population is Healthfirst-insured, postpartum women age 18 or older with one or more of the following eligibility criteria: hypertension, gestational diabetes, late registration to prenatal care, depressive symptoms, or residence in zip codes at high risk for hypertension or diabetes.

The goal is to enroll 510 women with Healthfirst insurance during their postpartum hospital stay.

The goal is to enroll 510 women with Healthfirst insurance during their postpartum hospital stay. The primary outcome is the timely postpartum visit (NCQA HEDIS measure 21–56 days postpartum); the secondary outcomes include gestational diabetes screening at the postpartum visit, maternal ED visits and hospitalizations within six months postpartum, and depressive symptoms. Study assessments occur at baseline (in-hospital survey) and follow up at two weeks, three weeks, and six months postpartum. The research team makes between two and seven attempts to complete the follow-up surveys (via telephone, email, or paper surveys) as well as to remind patients of their upcoming postpartum appointments.

Of 336 enrolled patients, more than 95% self-identify as black or Latina, 25% are Spanish-speaking, 11% have gestational diabetes, 25% have hypertension, 6% are late registrants to prenatal care, 15% have depressive symptoms (PHQ-2 $\geq$ 2), and 96% reside in zip codes with the highest tertile of HTN or diabetes. After 53 weeks of recruitment, 70% have completed a timely postpartum visit, 86% have completed a second-week follow-up call, 74% have completed the third-week survey, and 56% have completed the sixth-month postpartum survey. Study recruitment and data collection and analyses are ongoing. Interim results indicate improved rates of postpartum women among mothers with gestational diabetes and hypertension.

Continued on pg. 40

Clinical Partnerships

Continued from pg. 39

Project IMPACT: Advancing Primary Care

Over the years, Healthfirst has made concerted efforts to serve communities facing barriers to essential healthcare. South Asians, a group that includes Indians, Pakistanis, and Bangladeshis, among others, have disproportionately high rates of cardiovascular disease and often face cultural, linguistic, and social barriers to accessing needed healthcare.[3] One of our recent undertakings, Project IMPACT (Implementing Million Hearts for Provider and Community Transformation), seeks to change this.

The goal of this five-year, CDC-funded grant is to improve hypertension management for patients of small community-based practices that serve South Asian communities. Healthfirst is a key partner in this project because of our partnerships with physicians who serve the South Asian communities in Brooklyn and Queens. Susan J. Beane, VP and Medical Director, says of the project, "It is important to Healthfirst because it allows us to understand the process of advancing primary care and population health in the small community practices that so many of our members choose."

Through collaborative outreach efforts, eight Healthfirst primary care practices in neighborhoods such as Jackson Heights, South Richmond Hill, Jamaica, and Kensington have already enrolled in the project. They are currently receiving technical assistance on using Electronic Health Record (EHR) systems to implement evidence-based tools to improve hypertension management. After one year, community health workers will be embedded at each of the practices to provide culturally tailored health education and coaching to South Asian patients with hypertension.

Researchers from the NYU-CUNY Prevention Research Center are working with Healthfirst and the practices to understand the process and challenges of adopting these evidence-based tools at each of the practice sites. Healthfirst will collaborate with the research team to create systems that will pull together data on hypertension and related measures from the EHR systems at the practice sites in order to track changes in our members' blood pressures. We will also assess clinical outcomes and cost effectiveness through our claims data. Nadia Islam, PhD, Principal Investigator of Project IMPACT and Assistant Professor at NYU School of Medicine, explains, "The innovation of Project IMPACT is that it brings the benefits of healthcare reform directly into small primary care settings, enhancing the capacity of practices to effectively use population health management tools, leading to improved patient outcomes."

So far, we have learned that none of the enrolled practices routinely used EHR patient registry lists, alerts, or culturally adapted patient-educational materials. For each site, a specialized EHR consultant and the study team devoted several hours to training practice staff on patient registries and medical alerts.

The project is enrolling 15 practices into the study. If you lead a small primary care practice serving South Asian patients and are interested in learning more about the study, please contact Rashi Kumar at **rakumar@healthfirst.org** or at **1-212-547-3381**.

[3]Yi, S.S.; Thorpe, L.E.; Zonowiak, J.M.; Trinh-Shevrin, C.; and Islam, N.S. Clinical Characteristics and Lifestyle Behaviors in a Population-Based Sample of Chinese and South Asian Immigrants With Hypertension. Am J Hypertens, 2016 Feb 17. pii: hpw014 doi:10.1093/ajh/hpw014; www.ncbi.nlm.nih.gov/pubmed/26888778.

Healthfirst Clinical Documentation Improvement (CDI): What Does it Mean for You?

Providers should use the "grace period" to establish an effective audit protocol that addresses the challenges ICD-10-CM brings.

The effects of ICD-10-CM implementation have yet to be realized, and while CMS' 12-month moratorium that requires specificity of the ICD-10-CM diagnosis code reporting is current...**now** is the time to identify the misinterpretation of codes from ICD-9 to ICD-10-CM. Documentation practices are key to the success of ICD-10-CM, since the clinical documentation must reflect the coding specificity and granularity required to meet all regulatory and reporting requirements, optimize claims processing, mitigate risk, and demonstrate the quality of the care provided. Since ICD-10-CM is the fundamental vocabulary used to record the patient's state of health, it is also a key driver for coordination of care, and because it is more detailed, it demands clinical documentation that is as specific as the description within the code set.

Complete and accurate documentation and reporting at the point of care can ultimately streamline your processes, as the increased information will improve communication, increase recognition of comorbid conditions that respond to treatment, validate the care provided, and show compliance with quality and safety guidelines.

Is the documentation:

- Legible?
- Complete?
- Clear?
- Consistent?
- Precise?

Providers should use the "grace period" to establish an effective audit protocol that addresses the challenges ICD-10-CM brings. Here at Healthfirst we are dedicated to partnering with you to enhance your experience in the ever-changing aspects of the healthcare system so that you can continue providing optimal care to our members.

Stay tuned! More information on CDI will be coming soon!

Continued on pg. 42

Healthfirst Clinical Documentation Improvement (CDI): What Does it Mean for You?

Continued from pg. 41

ICD-10-CM Best Practices tips:

- **Laterality** is expanded in ICD-10-CM—clinical documentation for diagnoses should include information on which side of the body is affected (right, left, bilateral)
- **Injuries** are grouped by anatomical site instead of type of injury
- **Fractures**
  - Site
  - Laterality
  - Type/cause (e.g., open, closed, pathologic, stress)
  - Location (e.g., shaft, lower end, upper end)
  - Displacement (displaced, nondisplaced)
  - Fracture pattern (transverse, oblique, spiral, comminuted, segmental)
- **Diabetes**
  - Type
  - Control
  - Body system affected
  - Complication/manifestation
  - In type 2, long-term use of insulin
- **Otitis Media**
  - Incidence (acute, subacute, acute recurrent, chronic)
  - Laterality
  - Type (e.g., serous, suppurative or nonsuppurative, tubotympanic, allergic, mucoid)
- **Encounter type**
  - Initial
  - Subsequent
  - Sequelae
- **Healing type**
  - Routine healing
  - Delayed healing
  - Nonunion
  - Malunion

Predictive Analytics and Medication Adherence

As part of an early intervention strategy for medication adherence, Healthfirst has been working with a predictive analytics company to stratify members who are most and least likely to be adherent to their medications in the three adherence measures. In February, you may have received a report on your Healthfirst patients' medication adherence risk scores in the diabetes, cholesterol, and hypertension medication adherence measures for first quarter 2016.

This information was provided to you so that you can outreach members who have a higher chance of being nonadherent in 2016 and prevent them from falling below the 80% Proportion of Days Covered (PDC) threshold.

The report included a list of your members and their adherence risk scores based on their behaviors over the past two years. PDC scores for 2013 through 2015 were also provided per each measure the member qualifies for. The risk scores are categorized as follows:

- **Highest-Risk Tiers—members who are most likely to be nonadherent**
  - Risk Tiers 1 and 2: very high-risk members who generally achieve a PDC < 50%
  - Risk Tiers 3 and 4: include members who generally achieve a PDC < 70%
- **Middle-Risk Tiers—members on the cusp of adherence**
  - Risk Tiers 5 and 6: include members who are between a PDC of 70% and 80%
- **Lowest-Risk Tiers—members who are most likely to be adherent**
  - Risk Tiers 7 and 8: include members that generally achieve a PDC > 80%
  - Risk Tiers 9 and 10: lowest-risk members who generally achieve a PDC > 90%

We believe that early intervention and education of these highest- and middle-risk members at the beginning of the year could positively impact their adherence. As you interact and care for our members on a regular basis, we encourage you to use this report to address these members and help them overcome their medication-adherence barriers.

We believe that early intervention and education of these highest- and middle-risk members at the beginning of the year could positively impact their adherence.

Medicaid, CHP, Personal Wellness Plan Formulary Announcement

As of April 1, 2016, there were several changes made to the Managed Medicaid, Child Health Plus, and Personal Wellness Plan formularies to allow Healthfirst to continue to provide affordable and quality health insurance to our members. **The most significant change we made is the removal of Januvia®, Janumet®, and Janumet XR® from the formulary. This change made Tradjenta® and Jentadueto® our preferred DPP-4 inhibitors, beginning April 1, 2016, for Managed Medicaid, Child Health Plus, and the Personal Wellness Plan.** To limit the disruption to our members, here are some tips that can help you and your staff with this change:

- If a member was previously taking Januvia/Janumet/Janumet XR, they will **NOT** require a new prior authorization to use Tradjenta or Jentadueto
- Once current authorizations expire for Januvia/Janumet/Janumet XR, you will have to complete the formulary exception process for continued coverage of these drugs. New prescriptions for Tradjenta or Jentadueto will **NOT** require any prior authorization forms to be completed for coverage

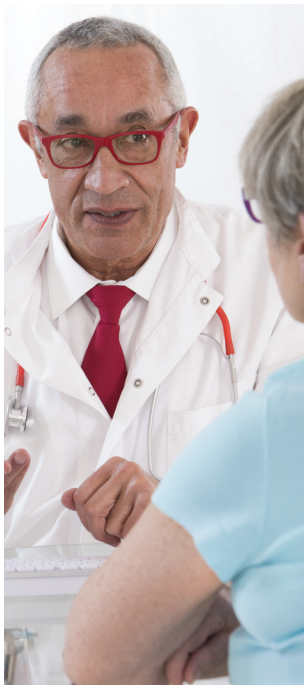
In addition to making Tradjenta and Jentadueto our preferred DPP-4 inhibitors, here are some other changes that went into effect on April 1, 2016. Please visit **www.healthfirst.org/formulary** for additional information.

2016 Medicaid, Child Health Plus, and Personal Wellness Plan Formulary Changes *(Effective 4/1/2016)*

Therapeutic Category	Drug Name	Formulary Change	Preferred Formulary Alternative
Cardiovascular	Entresto® *(Sacubitril/Valsartan)*	**Added to Formulary**	
Androgens	Androgel® 1% *(Testosterone Gel 25mg/2.5g)*	**Added to Formulary**	Androgel® 1%
	Axiron® Solution *(Testosterone 30mg/Actuation)*	**Removed from Formulary**	
Opioid-Induced Constipation	Movantik® *(Naloxegol Oxalate)*	**Added to Formulary**	
DMARDs	Otrexup® *(Methotrexate soln)*	**Added to Formulary**	
Inhaled Anticholinergics	Incruse Ellipta® *(Umeclidinium Bromide)*	**Added to Formulary**	Incruse Ellipta® Spiriva Handihaler® Spiriva Respimat®
	Turdoza® *(Aclidinium Bromide)*	**Removed from Formulary**	
Cystic Fibrosis	Kalydeco® *(Ivacaftor);* Orkambi® *(Lumacaftor/Ivacaftor)*	**Added to Formulary**	
Acne	*Erythromycin/Benzoyl Peroxide Gel* (Combo Product)	**Removed from Formulary**	*Erythromycin Gel Benzoyl Peroxide Gel*
Dermatology	Pentravan® Pentravan Plus®	**Removed from Formulary**	
Anti-infectives	Sivextro® *(Tedizolid)*	**Removed from Formulary**	*Linezolid*– Tabs, IV Solution Zyvox®– Oral Suspension
	Linezolid Tabs, IV Soln	**Added to Formulary**	
	Zyvox® *(Linezolid)* Oral Susp	**Added to Formulary**	

Urinary Incontinence and Overactive Bladder

Whether you are a general practitioner, gynecologist, urologist, or other healthcare provider, it's important to know how to talk to your patients about urinary incontinence (UI) and overactive bladder (OAB). Failure to get treatment for UI or OAB can negatively impact your patient's quality of life and cause embarrassment or social isolation.



If some of your patients who are Healthfirst members reach out to you with questions or concerns about UI or OAB, we want you to have all the information you need to answer their questions and deliver quality care.

We have compiled general information, conversation starters, concomitant diseases, and drugs that affect continence so you can successfully address the inquiries you may receive from your patients with UI and OAB.

Conversation starters

The following conversation starters were taken from the Urology Care Foundation's toolkit on talking to your patients about overactive bladder. You may download the fact sheet at **www.urologyhealth.org/educational-materials/how-to-talk-to-your-patients-about-overactive-bladder**.

Help to dispel myths about OAB. While age-related changes increase the risk for OAB, it is not inevitable. There are many treatments for OAB to help your patients manage their symptoms.

- Assure your patients that urinary problems are very common and that you are comfortable talking to them about their symptoms
- Avoid statements that tell a patient how he or she should feel. Instead of saying "You should not be embarrassed to discuss this," you might say, "I understand that incontinence may be an embarrassing topic to discuss, but there is a lot that can be done to reduce urinary symptoms, and it can be medically important to find their cause"
- Ask your patient specific questions about their symptoms to make it easier to discuss treatment and provide information

Concomitant diseases that may have an impact upon urinary continence (Gadgil, S.; Wagg, A. Management of urinary incontinence in older people. Prescriber April 2008: 35–42)

Diseases affecting mobility	■ arthritis ■ hip fracture ■ contractures ■ peripheral vascular disease ■ stroke ■ Parkinson's disease
Nervous system disorders affecting cognition and neural control mechanisms	■ dementia ■ stroke ■ Parkinson's disease
Other medical conditions	■ diabetes mellitus—causing polyuria and autonomic neuropathy ■ congestive heart failure—leading to excess nocturnal urine production ■ venous insufficiency—a similar mechanism ■ chronic lung disease—exacerbation of stress incontinence

Continued on pg. 48

Urinary Incontinence and Overactive Bladder

Continued from pg. 47

Drugs that can affect continence (Cook, K.; Sobreski, L. Urinary incontinence in the older adult. PSAP 2013 Special Populations)

Drug	Effects on Continence
Alcohol	Increased frequency, urgency, sedation, immobility
α-Adrenergic agonists	Outlet obstruction (men)
α-Adrenergic blockers	Stress leakage (women)
ACE inhibitors	Cough worsens stress incontinence
Anticholinergics	Impaired emptying, retention, delirium, sedation, constipation, fecal impaction
Antipsychotics	Anticholinergic effects plus rigidity and immobility
Calcium channel blockers	Impaired detrusor contractility and retention; dihydropyridine agents can cause pedal edema, leading to nocturnal polyuria
Cholinesterase inhibitors	Urinary incontinence, interactions with antimuscarinics
Estrogen	Worsens stress and mixed leakage in women
GABAnergic agents (gabapentin and pregabalin)	Edema causing nocturia and nighttime incontinence
Loop diuretics	Polyuria, frequency, urgency
Narcotic analgesics	Urinary retention, fecal impaction, sedation, delirium
NSAIDs	Pedal edema causing nocturnal polyuria
Sedative hypnotics	Sedation, delirium, immobility
Thiazolidinediones	Pedal edema causing nocturnal polyuria

ACE = angiotensin-converting enzyme;
GABA = γ-aminobutyric acid;
NSAID = nonsteroidal anti-inflammatory drug;
TCA = tricyclic antidepressant. Adapted with permission from: Reuben DB, Herr KA, Pacala JT, et al. *Geriatrics at Your Fingertips,* 14th ed. New York: American Geriatrics Society, 2012.

Spectrum of Health Bulletin

The Spectrum of Health bulletin on Management of Incontinence and Pelvic Floor Disorders contains tools for screening, assessment, and patient education that can be of value to you and your staff in caring for your patients with incontinence. You may download the bulletin at **www.healthfirst.org/providers/clinical-partnerships/spectrum-health**.

If you have any questions or need additional information, please contact your Network Account Manager.

Shortness of Breath

Shortness of breath is a serious and complex condition. Along with diagnosis and treatment, patients require attention to their physical and emotional needs and quality of life.

We have compiled information on referrals, resources, and action plans that you can use to continue to offer your patients who are Healthfirst members the best possible care.

COPD Action Plan

Help your patients manage their shortness of breath. With this 3-in-1 personal COPD Management Tool from the American Lung Association, your patients can:

- Stay adherent to medication
- Know when to contact a doctor
- Get emergency care
- Track progress, concerns, and changes in health

THE COPD Management Tool is available at **www.lung.org/assets/documents/copd/copd-action-plan.pdf**.

Referring to a Pulmonologist

Does your patient need a referral? Use our provider lookup tool—**www.hfdocfinder.org**—to find an in-network pulmonologist.

When to Recommend Pulmonary Rehabilitation

Pulmonary Rehabilitation (PR) is an education and exercise program that teaches patients about their conditions, how to be more active, and how to manage shortness of breath. PR can improve pulmonary function and mobility and often takes place in group settings, offering patients social support.

PR may benefit patients with COPD, Sarcoidosis, Idiopathic Pulmonary Fibrosis, or Cystic Fibrosis by improving strength and conditioning and reducing hospital visits. PR is usually recommended for patients who have shortness of breath and reduced exercise tolerance despite using medication, and when conditions become severe. Recommend PR to your eligible patients.

Spectrum of Health Bulletin

Many patients with shortness of breath struggle with smoking cessation. *The Spectrum of Health* bulletin on Smoking Cessation contains tools for screening, assessment, and patient education. You may download the bulletin at **www.healthfirst.org/providers/clinical-partnerships/spectrum-health**.

Sources

"Pulmonary Rehabilitation," American Lung Association. Accessed March 18, 2016. www.lung.org/lung-health-and-diseases/lung-disease-lookup/copd/diagnosing-and-treating/pulmonary-rehabilitation.html

"What is Pulmonary Rehabilitation?," National Heart, Lung, and Blood Institute. Updated August 1, 2010. www.nhlbi.nih.gov/health/health-topics/topics/pulreh

Children with Asthma
What's Your Plan?

An Asthma Action Plan (AAP) is an important self-management tool for our young members and their parents to understand the best ways to control daily asthma symptoms, avoid triggers, manage medications, and know when to call their doctor or seek emergency care.

In order for the AAP to be effective, the National Heart, Lung, and Blood Institute (NHLBI) offers these tips when providing education to patients and their families:

- Choose treatment that achieves the results and considers the preferences that are important to the patient/family
- Review at each visit any success in achieving control, concerns about treatment, difficulties following the plan, and barriers to adherence
- Build patient confidence by providing encouragement and praise. Engage families to be involved with the patient's AAP implementation
- Customize the plan to meet the needs and literacy levels of the patient as well as maintain sensitivity to his/her cultural beliefs and practices
- Assess skills for self-management (e.g., inhaler technique, use of a spacer, and self-monitoring)

Reinforce the importance of having the parent share a copy of the AAP with the child's teachers, school nurse, and other school officials so that the people in the child's life, including relatives and friends, are well-informed in case the child has an asthma attack.

Please partner with our members and their families when developing an AAP and ensure that it is updated every six months. Reinforce the importance of having the parent share a copy of the AAP with the child's teachers, school nurse, and other school officials so that the people in the child's life, including relatives and friends, are well-informed in case the child has an asthma attack.

For more information on AAPs, asthma clinical guidelines, assessment tools, and member educational materials, please visit **www.healthfirst.org**.

Source

www.nhlbi.nih.gov/health-pro/resources/lung/naci/discover/action-plans.htm

Preventing COPD Readmissions

In order to ensure that our members are able to take advantage of their medication benefits, please ensure that you prescribe a medication from Healthfirst's formulary.

The Global Initiative for Chronic Obstructive Lung Disease and the National Committee for Quality Assurance (NCQA) recommend that individuals with COPD, chronic bronchitis, and/or emphysema should be prescribed a **systemic corticosteroid and a bronchodilator upon discharge** from an inpatient admission or ED visit due to an acute exacerbation.

In order to ensure that our members are able to take advantage of their medication benefits, please ensure that you prescribe a medication from Healthfirst's formulary. As their physician, your reinforcement regarding the importance of taking the systemic corticosteroid and bronchodilator **within 14 days and 30 days from discharge**, respectively, in order to prevent a relapse is a key factor in member compliance.

Below is a limited list of our covered drugs. You can access our complete formulary at **www.healthfirst.org/formulary**.

Formulary Systemic Corticosteroids*

Medicaid	Dexamethasone tabs	Fludrocortisone tabs	Hydrocortisone tabs
	Methylprednisolone tabs	Prednisolone ODT, sol	Prednisone tabs, syp
Medicare	Dexamethasone tabs, elix, sol, inj	Fludrocortisone tabs	Hydrocortisone tabs
	Methylprednisolone tabs, inj	Prednisolone sol, syp	Prednisone tabs, sol, syp

Formulary Bronchodilators*

Medicaid	Anticholinergic agents	Incruse Ellipta	Combivent Respimat	Ipratroprium–albuterol inh sol
		Ipratropium inh sol	Spiriva Respimat, Handihaler	
	Beta 2 Agonists	Albuterol inh sol	ProAir HFA	Ventolin HFA
		Foradil	Arcapta Neohaler	Striverdi Respimat
		Symbicort	Dulera	
	Methylxanthines	Theophylline liquid, XR		
Medicare *(italics indicates preferred brand)*	Anticholinergic agents	*Incruse Ellipta*	Ipratropium inh sol	*Anoro Ellipta*
		Combivent Respimat	Ipratropium–albuterol inh sol	
	Beta 2 Agonists	Albuterol inh sol	Levalbuterol inh sol	Xopenex HFA
		Ventolin HFA	Perforomist	*Serevent Diskus*
		Advair Diskus, HFA	*Breo Ellipta*	*Symbicort*
	Methylxanthines	Aminophlline inj	Elixophyllin	*Theophylline, XR*

*Quantity limits may apply. The Medicaid formulary is subject to change on a quarterly basis; Medicare's on a yearly.

Also, encourage our members to **quit smoking now!** Let them know that smoking increases the progression of their COPD and triggers flare-ups which may result in an ED visit or hospitalization.

Provide them with smoking cessation counseling and medication, and refer them to the NYS Quitline (**1-866-NY QUITS** or **www.nysmokefree.com**) to support their efforts. For more tobacco use information and resources, visit our website at **www.healthfirst.org**.

Healthy Eating

In 2010, one-quarter of deaths in the United States were associated with dietary risk factors, and two-thirds of Americans were overweight or obese.

Healthy eating patterns can promote overall health, lower the risk of obesity, and help prevent or, in some cases, control many chronic diseases and conditions, including cardiovascular disease, type 2 diabetes, hypertension, high cholesterol, and some cancers. Yet most New Yorkers, like most Americans, do not meet national recommendations for healthy eating. In 2013:

- Three-quarters (76%) of New York City adults said they had eaten fewer than the recommended five servings of fruits and vegetables on the previous day—another 13% had eaten none
- The lowest rates of fruit and vegetable consumption occurred in the lowest-income neighborhoods, where fresh, nutritious food is often difficult to find or afford
- Nearly one-quarter (23%) of adult New Yorkers said they drink one or more sugary beverages daily
- Nearly 1 in 5 (18%) reported exceeding the recommended daily limit for alcohol consumption in the past month
- More than half (60%) said they don't consider sodium content when buying food

Helping Patients Make Healthy Eating Choices

- Talk to every patient about healthy eating—everyone can benefit
- Explain the healthy eating basics: preference, portions, and proportion
- Use a simple educational tool such as the **Healthy Eating Plate** to focus the conversation
- Work with your patient to set realistic goals
- Document goals and follow up at each visit

Source

www1.nyc.gov/assets/doh/downloads/pdf/chi/chi-34-7.pdf

The Benefits of Physical Activity for Your Patients

Regular physical activity is one of the most important things your patients can do for their health.

While some of your patients may be unsure about becoming active or boosting their level of physical activity because they're afraid of getting hurt, the good news is that **moderate-intensity aerobic activity**, like brisk walking, is generally **safe for most people**.

Start slowly. Cardiac events, such as a heart attack, are rare during physical activity. But the risk does go up when your patients suddenly become much more active than usual. For example, your patients can put themselves at risk if they don't usually get much physical activity and then all of a sudden do vigorous-intensity aerobic activity, like shoveling snow. That's why it's important for them to start slowly and gradually increase their level of activity.

If your patients have a chronic health condition such as arthritis, diabetes, or heart disease, talk with them to find out if their condition limits in any way their ability to be active. Then work with your patients to come up with a physical activity plan that matches their abilities. If their condition stops them from meeting the minimum *Guidelines*, they can try to do as much as they can. What's important is that they avoid being inactive. Even 60 minutes a week of moderate-intensity aerobic activity is good for them.

The bottom line is that the health benefits of physical activity far outweigh the risks of getting hurt.

Source

www.cdc.gov/physicalactivity/basics/pa-health/index.htm

Preventing Falls in Older Adults

- A fall can mean an end to independent living, or it can even mean death, for adults age 65 years and older
- Make annual screening for risk of falls a priority with all older patients and perform a multifactorial evaluation of those at risk
- Use **CDC's STEADI toolkit** to integrate fall prevention into routine clinical care
- Recommend regular physical activity, correction of home hazards, and medication adjustments to reduce fall risk

Fall Prevention Strategies

A multifactorial approach to preventing falls will be more effective than any single intervention. This approach might include strength and balance training, correction of home hazards, and medication adjustment. Be sure to include caregivers and family when discussing the fall prevention plan. Follow up with your patient at subsequent visits to make sure that he or she has made and maintains the recommended changes.

Be sure to include caregivers and family when discussing the fall prevention plan.

Fall Prevention Tools

- Stopping Elderly Accidents, Deaths & Injuries (STEADI) Toolkit: **www.cdc.gov/steadi**
- Falls Prevention Checklist: **www.cdc.gov/steadi/pdf/check_for_safety_brochure-a.pdf**

Dilated Retinal Exam

Help your patients with diabetes get the care they need.

Current Data and Trends

Diabetes is the leading cause of new cases of blindness among adults ages 20 to 74 years. Approximately 11.0% of U.S. adults with diabetes have some form of visual impairment (3.8% uncorrectable and 7.2% correctable). Of late, 4.2 million people with diabetes age 40 years or older (28.5%) had diabetic retinopathy (DR). Of these, 655,000 had advanced DR that could lead to severe vision loss. DR is projected to affect 16 million people with diabetes by 2050. Other diseases, like cataracts and glaucoma, also are projected to increase in this population.

The American Diabetes Association (ADA) recommends that children age 10 years or older and adults with type 1 diabetes have an initial dilated comprehensive eye exam by an optometrist or ophthalmologist within five years after the onset of diabetes, and that patients with type 2 diabetes undergo an examination shortly after diagnosis of the disease. As much as 21% of patients with newly diagnosed type 2 diabetes will have retinopathy at diagnosis.

You may be the first to see a person with, or at risk for, diabetes.

Key questions that all members of the healthcare team should ask patients about eye health

Patients should be referred to an optometrist or other eye care professional if the answers to these questions are "no" or "unsure":

- **Do you get a full eye exam with dilated pupils at least once a year?** This is important because diabetes can affect your eyes without any signs or symptoms
- **Do you know how diabetes can affect your eyes?**
- **Do you know what to do if you suddenly have a change in your vision?**

You can make a difference. You and other providers of pharmacy, podiatry, optometry, and dentistry (PPOD) care are well positioned to advise and educate your patients about diabetes prevention and management. You may be the first to see a person with, or at risk for, diabetes.

Source

www.cdc.gov/diabetes/ndep/pdfs/ppod-guide-eye-care-professionals.pdf

Keep Your Profile Current

Keeping updated contact information is essential for ensuring appropriate access to care for our members.

To avoid a poor experience for our members, we at Healthfirst want to ensure our directory has the most up-to-date information for your practice.

As you are aware, we conduct audits throughout the year to ensure you are providing timely access to appointments and that your demographic information is up-to-date.

Remember, your information matters to us, but more importantly it impacts our members. It takes only one wrong phone number or office address for the member to perceive a barrier to accessing their care. Access and availability is essential to our star rating, but more importantly to a healthy and happy member experience. Below are directions for how to easily update your information.

Provider Information

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, to comply with provider information reporting requirements mandated by governmental and regulatory authorities, and to provide the most up-to-date information on provider choices to our members. Changes and updates should be submitted at least thirty days before the effective date. Any changes to the following list of items should be reported to Healthfirst via our electronic Demographic Change Form, found on the Secure Provider Portal; or changes can be faxed to Healthfirst at **1-646-313-4634/Attn: Demographic Update Request**.

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

These should be submitted with a fax cover sheet that includes full contact information, along with 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 faxed with these requests.

- 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 practice's office 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

Remember, your information matters to us, but more importantly it impacts our members. It takes only one wrong phone number or office address for the member to perceive a barrier to accessing their care.

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.

First Tier, Downstream and Related Entities (FDR) Attestation

As a valued partner providing services to Healthfirst members, your compliance with State and Federal regulations is essential. **All First Tier, Downstream and Related Entities (FDRs) and Affiliates, including physicians, hospitals, DMEPOS suppliers, and specific vendors, were to have completed the Healthfirst FDR & Affiliate Compliance Attestation for 2016, found at www.healthfirstfdr.org**. The Compliance Attestation covers the following requirements:

- Standards of Conduct, Compliance Policies, and Compliance Information;
- Fraud, Waste, and Abuse (FWA) and Compliance Training;*
- OIG, GSA (SAM) and New York State (NYS) Exclusion Screening;
- Fraud, Waste, and Abuse and Compliance Issues Reporting Mechanisms; and
- Offshore Subcontracting.

*Please note that the FWA and Compliance Training requirement has changed, effective January 2016, based on guidance from the Centers for Medicare & Medicaid Services (CMS). Per the HPMS Memo *Additional Guidance–Compliance Program Training Requirements and Audit Process Update* dated February 10, 2016:

"Sponsors and/or FDRs will have three (3) options for ensuring FDRs have satisfied the general compliance training requirement:

1. FDRs can complete the general compliance and/or FWA training modules located on the CMS MLN. Once an individual completes the training, the system will generate a certificate of completion.
2. FDRs can incorporate the content of the CMS standardized training modules from the CMS website into their organizations' existing compliance training materials/systems.
3. FDRs can incorporate the content of the CMS training modules into written documents for providers (e.g., Provider Guides, Participation Manuals, Business Associate Agreements, etc.)."

Information on the CMS requirement, along with links to the courses and training material, can be accessed at **www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Waste_Abuse-Training_12_13_11.pdf**.

Please be advised that all FDRs and what they attest to are subject to audit by Healthfirst. Healthfirst will notify you, in writing, regarding the audit requirements and timeframes if you have been chosen for the current year's audit.

If at any time you have any questions about the attestation, please contact **Compliance@healthfirst.org** or call 1-212-324-2699 to speak with a representative from the Healthfirst Compliance 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**
- Filing a report via the Confidential Website Address: **www.hfcompliance.ethicspoint.com**

Read more at **www.healthfirstny.org/compliance.html**.

Please be advised that all FDRs and what they attest to are subject to audit by Healthfirst.

Network Updates

Americans with Disabilities Act (ADA) Attestation

The Americans with Disabilities Act (ADA) requires that reasonable accommodations are made for persons with disabilities, specifically in their access to healthcare. The ADA Attestation is a questionnaire that verifies a provider's compliance with the ADA accessibility standards. The results of the ADA Attestation are included in Healthfirst's provider directory. These results help Healthfirst participants identify which providers offer specified accessibility features.

All Healthfirst providers must fill out and submit the ADA Attestation for each of their locations. ADA Attestations must be completed online at **https://healthfirstada.org/**.

CMS Prescriber Enrollment Requirements

CMS is delaying enforcement of the Part D Prescriber Enrollment Requirements until February 1, 2017.

Beginning February 1, 2017, CMS will enforce a requirement that Medicare Part D prescription drug benefit plans may not cover drugs prescribed by providers who aren't enrolled in (or who have validly opted out of) the Medicare Program. Providers must enroll in Medicare in order to prescribe drugs covered by a Medicare Advantage plan. If a provider chooses to opt out of Medicare, they will not be eligible to receive reimbursement, either directly or indirectly, for items and services covered by traditional Medicare or a Medicare Advantage plan except for emergency and urgent care services. Physicians who have opted out are locked into the opt-out status for two years; if they wish to terminate their opt-out status early, they must do so within 90 days of the start of the two-year period.

Medicare Part D prescribers need to take action and enroll in or opt out of Medicare as soon as possible. Delays in doing so could result in Medicare patients not being able to obtain drugs prescribed for them. We recommend visiting **https://go.cms.gov/prescriberenrollment**, where you can:

- Check your enrollment status
- Enroll using PECOS, the online application
- Opt out of Medicare Part D

Updated EviCore Code List

The 2016 EviCore code listing of Radiology and Radiation Therapy services that require authorization is now available at **www.healthfirst.org/providers/claims-billing**.

New Healthy Living Blog

Want to help your patients achieve their health and wellness goals? Let them know about our new Healthy Living blog today. Our blog can be found at **www.HFHealthyLiving.org**. There your patients can discover a variety of posts, quizzes, and videos on:

- Fitness
- Recipes
- Lifestyle
- Parenting
- Managing health conditions

Plus, your patients can learn about Healthy Living events in the communities we serve, and much more.

Healthy Living starts at **www.HFHealthyLiving.org**.

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	Updated 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.

WEB

healthfirst®
Health Insurance for New Yorkers

PRSTD STD
U.S. POSTAGE
PAID
NEW YORK, NY
PERMIT# 2254

P.O. Box 5168, New York, NY 10274-5168

TheSource