TheSource

Fall 2014

healthfirst®

IN THIS ISSUE

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Marketing & Communications

From the Desk of the
Chief Medical Officer

Dear Valued Provider:

Welcome to the fall issue of *The Source*. Each quarter, we strive to provide your practice with the valuable information you need to care for our members, stay up-to-date on key initiatives, and navigate claims and compliance issues.

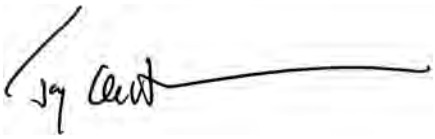
Our top story focuses on the transition from the current ICD-9 code set to ICD-10 that's planned for October 2015. This is a monumental undertaking and will affect everyone covered by HIPAA, including providers and payers who deal with Medicare or Medicaid claims. Not complying with this transition will result in rejected claims, and such noncompliance could deal a devastating blow to your practice. This is why you must educate and prepare your business now for this change, and why you should read our top story starting on page 3.

We are also entering the Open Enrollment periods for Medicare and the Qualified Health Plans that are part of the Health Exchange. This is an important time of the year, and several of this issue's stories focus on our plans for 2015, including an item on the grace period recapture clause that's part of the Affordable Care Act.

Flu season is here, and we have added a reminder about discussing immunizations with your patients. Preventive care is one of the most powerful tools in our doctor bags, so we've added helpful reminders regarding several screenings, including lead, cancer, and dental screenings, as well as physical fitness and injury prevention. While annual changes to HEDIS can influence the list of emphasized screenings, appropriate interventions can help your patients make great progress toward achieving their health goals.

Please take time to look through this issue, as it covers much more than the stories I've mentioned. The information we provide through *The Source* can go a long way toward improving your experience with our plan and our members' experiences with you as their provider.

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.
Senior Vice President
Chief Medical Officer

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

Continuing Our Commitment to ICD-10 Compliance

About ICD-10

As you know, the ICD-9 code sets will be replaced by the ICD-10 code sets. According to the Centers for Medicare & Medicaid (CMS), the transition to the ICD-10 code set is occurring because the ICD-9 code set has limited data, outdated terms, and is inconsistent with current medical practice.

ICD-10 CM/PCS (International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System) consists of two parts:

ICD-10-CM (diagnosis coding) was developed by the Centers for Disease Control and Prevention for use in all U.S. healthcare settings. Diagnosis coding under ICD-10-CM uses 3 to 7 digits instead of the 3 to 5 digits used with ICD-9-CM, but the format of the code sets is similar.

ICD-10-PCS (inpatient procedure coding) was developed by the Centers for Medicare & Medicaid Services (CMS) for use in U.S. inpatient hospital settings only. ICD-10-PCS uses 7 alphanumeric digits instead of the 3 or 4 numeric digits used under ICD-9-CM procedure coding. Coding under ICD-10-PCS is much more specific and is substantially different from ICD-9-CM procedure coding.

The transition to ICD-10-CM/PCS does not affect Current Procedural Terminology (CPT) codes, which will continue to be used for professional services. However, a compliant diagnosis code is required in order to properly adjudicate your claim.

ICD-10 compliance date delayed until October 1, 2015

"On April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. No. 113-93) was enacted, which said that the Secretary may not adopt ICD-10 prior to October 1, 2015. Therefore, the industry is awaiting an interim final rule from the U.S. Department of Health and Human Services in the near future with a new compliance date for the use of ICD-10 codes beginning October 1, 2015. The rule is also expected to require HIPAA covered entities to continue to use ICD-9-CM through September 30, 2015."[1]

In view of the recently passed legislation that delays ICD-10 implementation, we continue to move forward with our commitment to be ICD-10 compliant. However, we are assessing our overall implementation schedule. Additional information regarding our work activities and overall timeline will be posted in the coming months in the ICD-10 Information section of our website.

Healthcare providers, payers, clearinghouses, and billing services are required to comply with the transition to ICD-10, which means:

- ICD-10 diagnosis codes will be used for all healthcare services.
- ICD-10 procedure codes will be used for all hospital inpatient procedures. Please note that the change to ICD-10 does not affect CPT coding for professional services.
- All electronic transactions must use Version 5010 standards.

Continued on page 4

Source:

[1] www.cms.gov/Medicare/Coding/ICD10/Latest_News.html.

Continuing Our Commitment to ICD-10 Compliance *(Continued from page 3)*

General Claims Submissions Information

As communicated by CMS, on or after October 1, 2015, ICD-9 codes will no longer be accepted on claims (including electronic and paper) with FROM dates of service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims). Institutional claims containing ICD-9 codes for services on or after October 1, 2015, will be denied. Likewise, professional and supplier claims containing ICD-9 codes for dates of service on or after October 1, 2015, will also be denied. You will be required to re-submit these claims with the appropriate ICD-10 code. A claim cannot contain both ICD-9 codes and ICD-10 codes. Please see the guidance on how to handle claims that span the implementation date.

Healthfirst will deny all claims that are billed with **both** ICD-9 and ICD-10 **diagnosis codes** on the same claim. For dates of service **prior to** October 1, 2015, submit claims with the appropriate ICD-9 diagnosis code. For dates of service on or after October 1, 2015, submit with the appropriate ICD-10 diagnosis code. Likewise, Healthfirst will also deny all claims that are billed with **both** ICD-9 and ICD-10 **procedure codes** on the same claim. For claims with dates of service prior to October 1, 2015, submit with the appropriate ICD-9 procedure code. For claims with dates of service on or after October 1, 2015, submit with the appropriate ICD-10 procedure code. Remember that ICD-10 codes may be used only for services provided on or after October 1, 2015. Institutional claims containing ICD-10 codes for services prior to October 1, 2015, will be denied. Likewise, professional and supplier claims containing ICD-10 codes for services prior to October 1, 2015, will be denied. Please submit these claims with the appropriate ICD-9 code.

It is important to remember that providers are expected to utilize the appropriate ICD qualifier (Diagnosis Type Code within the ASC X12 v5010 standard). Healthfirst will use the ICD qualifier to distinguish between ICD-9 and ICD-10 code submissions. This means that if the qualifier indicates ICD-9, then the code must be a valid ICD-9 code; if the qualifier indicates ICD-10, then the code must be a valid ICD-10 code. Mixing the qualifiers and diagnosis codes will result in your claim being denied.

Claims that Span the ICD-10 Implementation Date

As communicated by CMS, there are potential claims-processing issues for institutional, professional, and supplier claims that span the implementation date; that is, where ICD-9 codes are effective for the portion of the services that were rendered on September 30, 2015, and earlier and where ICD-10 codes are effective for the portion of the services that were rendered on October 1, 2015, and later. Our remediation plan for these scenarios will comply with the CMS billing requirements outlined in the MLN Matters® Number: MM7492 **(www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7492.pdf)**.

Healthfirst's Approach to ICD-10

What is Healthfirst's recommendation for network providers regarding the transition to ICD-10?

Physicians, facilities, home care agencies, and ancillary providers that have not yet begun planning for the transition to ICD-10 need to begin immediately. Those who have already begun ICD-10 transition plans should continue to enact their plans to ensure a successful transition. Implementation planning is critical to the success of ICD-10 and the continuance of accurate and timely payments to your organization.

What is your approach to testing? Will you conduct testing with providers?

Large-scale internal testing of ICD-10 started during the second quarter of 2014. Targeted external testing will follow in the fourth quarter of 2014. Testing will continue through 2015. We will contact you directly if we plan to test with you. We select testing partners based on several factors. One factor is ICD-10's effect on the contract's reimbursement methodology and volume of claims payment. Contact your clearinghouse partners to initiate test planning in order to ensure readiness.

What is Healthfirst doing to prepare for the ICD-10 conversion?

Impacted areas are doing business and gap assessments. We have initiated a multiyear plan which incorporates system design and mitigation, development of business processes and policies,

and communication and training for those affected. We have leveraged industry leaders and consultants to assist with our planning and strategy to help us ensure a smooth transition for both the plan and our providers.

What should physician practices and facilities do to prepare for the new October 1, 2015, ICD-10 compliance date?

Although October 1, 2015, may seem far off, the complexity of conversion requires immediate and ongoing action to address business and clinical issues associated with the transition. The ICD-10 conversion affects nearly all provider systems and many processes. The largest impacts will likely be on clinical and financial documentation, billing, and coding. It is critical not to delay planning and preparation. It is important that providers contact their billing or software vendor to understand their plans for conversion and testing.

Will the ICD-10 conversion have an effect on provider reimbursement and contracting?

Possibly. We are evaluating the impact of ICD-10 on our contracting and clinical operations. The ICD-10 conversion is not intended to transform payment or reimbursement. However, it may result in reimbursement methodologies that more accurately reflect patient status and care.

What is Healthfirst's approach to mapping ICD-9 codes to the ICD-10 codes?

CMS has provided General Equivalency Mappings (GEMs) as an approach to define reasonable alternatives for mappings between ICD-9 and ICD-10 codes in both directions. While the GEMs provide guidance and a starting point for crosswalk development, there is currently no industry standard for mapping. As such, we have contracted with an industry-reputed vendor with ICD-10 expertise to assist us with fine-tuning the crosswalk between ICD-9 and ICD-10 for benefit design.

Will Healthfirst use a crosswalk for claims processing?

No, we will not use a crosswalk for claims processing. Starting on October 1, 2015, standard transactions must be submitted with ICD-10 codes. After that date, we will process claims submitted with ICD-9 codes only for dates of service (outpatient) or dates of discharge (inpatient) **prior** to October 1, 2015.

What happens if my claim does not have an ICD-10 code?

If your claim does not include a compliant ICD-10 diagnosis for dates of service beginning October 1, 2015, then your claim will be denied with an explanation code stating, "CLAIM DENIED: ICD9 AFTER TRANSITION – ICD10 REQUIRED."
It is critical that all provider types include compliant and appropriate diagnosis codes on all claim forms (i.e., paper and electronic) beginning October 1, 2015.

How will Healthfirst distinguish an ICD-9 code from an ICD-10 code?

Providers are expected to utilize the appropriate ICD qualifier (Diagnosis Type Code within the ASC X12 v5010 standard). Healthfirst will use the ICD qualifier to distinguish between ICD-9 and ICD-10 code submissions. This means that if the qualifier indicates ICD-9, then the code must be a valid ICD-9 code; if the qualifier indicates ICD-10, then the code must be a valid ICD-10 code.

Will Healthfirst support dual intake of codes?

We plan to meet all applicable timeframes for compliance. We anticipate that our providers and clearinghouses will do the same. After the compliance date, we will process claims submitted with ICD-9 codes only for dates of service (outpatient) or dates of discharge (inpatient) prior to October 1, 2015. We will continue to closely follow the communications from the regulatory authority and will adapt our approach as permitted.

When will Healthfirst accept ICD-10 codes on prior authorizations?

Healthfirst will begin accepting prior authorizations with ICD-10 codes on August 1, 2015, for dates of service or dates of admission of October 1, 2015, and beyond.

When will Healthfirst accept ICD-10 codes on inpatient notifications?

Healthfirst will begin accepting inpatient notifications with ICD-10 codes on August 1, 2015, for dates of service or dates of admission of October 1, 2015, and beyond.

When will Healthfirst accept ICD-10 codes on referrals?

Healthfirst will begin accepting referrals with ICD-10 codes on August 1, 2015, for dates of service of October 1, 2015, and beyond.

Resources and Tools

These industry resources will help with your planning and preparation:

- Centers for Medicare & Medicaid Services (CMS) official resources designed to help providers, payers, vendors, and noncovered entities with the transition to ICD-10 **www.cms.gov/icd10**
- Workgroup for Electronic Data Interchange (WEDI) **www.wedi.org**

Specialist Referrals: What You Need to Know

Healthfirst Leaf Plan members need a referral from their Primary Care Physician (PCP) for many specialist services. To simplify the specialist referral process and better coordinate care for our members, Healthfirst has teamed up with Emdeon to offer our providers access to their online referral system. Leaf Plan providers can access the Emdeon system through the Healthfirst Provider Portal at **www.healthfirst.org** or by visiting **https://office.emdeon.com/vendorfiles/healthfirst.html**.

While specialist referrals can be easily coordinated through Emdeon, Healthfirst Leaf Plan members do not need a PCP referral for the following:

- Emergency services
- OB/GYN visits
- Urgent care
- Outpatient behavioral health and substance abuse services

A complete list of specialists who participate in the Healthfirst Leaf Plan network is available at **www.hfdocfinder.org**. If you have any questions about specialist referrals, Healthfirst is here to help. Please call Provider Services at **1.888.801.1660**, **Monday to Friday**, **9am–5pm**.

Open Enrollment Update: Healthfirst Leaf Plans

Healthfirst is expanding our Leaf product offerings for 2015 to include new Leaf Premier Plans. These plans include adult vision and adult dental benefits in addition to all the existing benefits that are included with all Healthfirst Leaf Plans.

Open enrollment for Healthfirst's Leaf Plans runs from **November 15, 2014, to February 15, 2015**. During this time, new members can join one of our Leaf plans, which offer all the essential health benefits required by the Affordable Care Act and are sold on New York State of Health: The Official Health Plan Marketplace.

In 2015, the Healthfirst Leaf Plans will undergo some exciting changes that you should know about. Healthfirst has lowered their premium rates for 2015. This means that in 2015, Healthfirst members can expect to pay almost 12% less for the same great benefits they've come to expect from their Healthfirst Leaf Plan. Current Leaf Plan members will automatically be re-enrolled in their plan for 2015 (unless they take action to disenroll) and will automatically get the new, lower premium price.

In addition to our new Leaf Premier Plans, another change for Healthfirst Leaf Plans in 2015 is a broader geographic footprint. This year, Healthfirst has expanded our Leaf Plan network (currently in New York City and Nassau County) to cover members in Suffolk County, Long Island.

What if a Patient Misses a Payment?

Grace Period Rules for Healthfirst Leaf Plan Members

Healthfirst is committed to ensuring that our Leaf Plans meet all the government requirements for Qualified Health Plans mandated by the Affordable Care Act. One such legal requirement deals with what happens if a member misses one or more monthly premium payments. While most Healthfirst Leaf Plan members must make monthly payments to Healthfirst for their health insurance, missing a payment does not immediately cause a member to be disenrolled from their Healthfirst Leaf Plan.

Here's what you need to know about the law and grace periods for Healthfirst Leaf Plan members who miss a monthly payment:

- If a member misses a monthly premium payment, the account enters a "grace period."
- The grace period is a specific number of days that the insurance remains valid after a payment has been missed.
- During this grace period, the member can continue to use their Healthfirst Leaf Plan benefits as usual, and the member **cannot** be balance billed (as specified by New York State Law).
- A member whose account has entered the grace period can end the grace period for the account by paying the full amount owed.

The grace periods work differently for members who pay the full monthly premium than for members who receive subsidies to cover all or part of their monthly payment. Here's a summary of the differences:

Members Who Receive Subsidies for the Monthly Premium	Members Who Pay the Full Monthly Premium (No Subsidies)
Have a 90-day grace period	Have a 30-day grace period
Claims for services received during the first 30 days of the grace period will be processed and paid	All claims for services received on days 1–30 will be put on hold (marked as pending)
All claims for services received on days 31–90 of the grace period will be put on hold (marked as pending)	If the member pays the full premium owed by day 30 (final day) of the grace period, the pending claims will be processed and paid, if approved
If the member pays the full premium owed by day 90 (final day) of the grace period, the pending claims will be processed and paid, if approved	If the member does not pay the full premium owed by day 30, pending claims will be denied
If the member does not pay the full premium owed by day 90, pending claims will be denied	----------

Questions about the grace periods for Healthfirst Leaf Plans? Please contact Healthfirst Provider Services at **1.888.801.1660, Monday to Friday, 9am–5pm**.

Healthfirst's Quality Application for Provider Performance

The Healthfirst Quality Incentive Program (HQIP) seeks to advance Healthfirst's mission of providing our members with the highest possible quality and experience of care. Currently, HQIP participants receive monthly, quarterly, and member-specific reports tracking their performance, as well as a final report. Healthfirst is excited to share that a new, interactive reporting tool has been developed that will replace all existing quality reporting tools, including PDF-based reports, by 2015.

The Healthfirst Quality Application for Provider Performance (APP) is a web-based tool that will give providers access to all of their quality data in a central location. The tool will allow providers to analyze their data, create and export dynamic reports to Excel, and better focus on opportunities for improvement with continued support from Healthfirst staff. The Healthfirst Quality APP is being rolled out in phases, concluding in Fall/Winter 2014. Many providers already have access, and all providers eligible for HQIP will have access through the Provider Portal by January 2015.

For more information, please visit the Healthfirst Provider Portal at **www.healthfirst.org**. Should you have any questions about HQIP or the Healthfirst Quality APP, please contact your Network Representative. You may also email **HQIP@Healthfirst.org**.

Doctor Look-up Tool is Available

Finding information about Healthfirst doctors is easy. Our Doctor Look-up Tool gives you and your patients detailed provider information—including weekend hours, office locations, and hospital affiliation—in an easy-to-use navigation.

You can also send updated contact and practice information to providerupdates@healthfirst.org, print the full directory, or send information to a mobile device via text or email.

Visit www.HFDocFinder.org to access the provider directory and learn more about these features.

Provider Manual

To review and download the most current Provider Manual, please visit www.healthfirst.org.

Do we have your email address?

Don't miss important reminders and alerts. Visit us at **www.HFDocEmails.org** to sign up for email updates on information you need as a provider in the Healthfirst network.

Changes to HEDIS® 2015

There have been many changes to the measures we will be collecting data for and reporting to the Healthcare Effectiveness Data and Information Set (HEDIS) and STARS. The changes are outlined below.

Measures retired and no longer reported:

Cholesterol Management for Patients with Cardiovascular Conditions (CMC)

- LDL-C screening
- LDL-C control (<100 mg/dL)

Glaucoma Screening in Older Adults (GSO)

- LDL-C screening
- LDL-C control (<100 mg/dL)

Measures with significant changes:

Comprehensive Diabetes Care (CDC)

– Components retired
- LDL-C screening
- LDL-C control (<100 mg/dL)
- BP control (<140/80 mm Hg)

– Components still measurable
- Hemoglobin A1c (HbA1c) testing
- HbA1c poor control (>9.0%)
- HbA1c control (<8.0%)
- HbA1c control (<7.0%) for a selected population
- Eye exam (retinal) performed
- Medical attention for nephropathy
- BP control (<140/90 mm Hg)

Controlling High Blood Pressure (CBP)

The definition of adequate control has been revised to include two different BP thresholds based on age and diagnosis.

– Adequate control is defined as meeting any of the following criteria:
- Members 18–59 years of age whose BP was <140/90 mm Hg
- Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg
- Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg

Annual Monitoring for Patients on Persistent Medications (MPM)

– Components retired
- Annual monitoring for members on anticonvulsants rate

– Components still measurable
- Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)
- Annual monitoring for members on digoxin
- Annual monitoring for members on diuretics

– ACE inhibitors, ARB, digoxin, and diuretics rates no longer allow a blood urea nitrogen (BUN) therapeutic monitoring test to count as evidence of annual monitoring. Acceptable tests include:
- ACE/ARB - At least one serum potassium and a serum creatinine therapeutic monitoring test
- Digoxin - At least one serum potassium, at least **one serum creatinine, and at least one serum digoxin therapeutic monitoring test (new this year)**
- Diuretics - At least one serum potassium and a serum creatinine therapeutic monitoring test

Osteoporosis Management in Women Who Had a Fracture (OMW)

– Components changed
- Added an upper age limit; age criteria now 67-85
- Extended the look-back period for exclusions; now a two-year look-back period
- Removed estrogens from the drug therapy list
- Removed pathologic fractures from denominator
- Removed single-photon absorptiometry and dual-photon absorptiometry tests from the list of eligible bone density tests

Answers to Your Questions About

New York Enhanced Payments for Medicaid Providers

As you may already be aware, under the provisions set forth in the Affordable Care Act, effective January 1, 2013, managed care organizations (MCOs) reimburse eligible Medicaid Primary Care Physicians (PCPs) at least as much as the Medicare physician fee schedule (MPFS) rate in 2013 and 2014. What this means is that capitated and fee-for-service PCPs that are eligible will receive the enhanced Medicare rate. The New York State Department of Health (NYSDOH) maintains the list of eligible providers for a retroactive Primary Care Rate Increase (PCRI), and it is located at **www.health.ny.gov/health_care/medicaid/fees/**. This list is updated monthly (as needed) and distributed electronically to Healthfirst and other plans.

Working with Healthfirst and other MCOs, the NYSDOH also implemented a specific payment methodology for these eligible providers. Below are answers to your questions about Healthfirst's payment methodology.

I am a contracted Healthfirst PCP reimbursed for services through capitation. How did Healthfirst determine the enhanced payment for capitated services?

a. Healthfirst used the encounters and claims you submitted electronically or on paper documenting the eligible services given to members between January 1 and June 30, 2013. Healthfirst allocated the capitation you have been paid using the methodology outlined below:

NY Medicare/ACA Fee Schedule amount for eligible service	x	The number of units reported through submitted encounters	=	Medicare Repriced Amount			
Medicare Repriced Amount	/	Total Medicare Repriced Amount (across all capitated services)	x	Total Capitation Paid	=	Allocation Capitation Amount	
Medicare Repriced Amount	-	Allocation Capitation Amount	-	Member Responsibility (cost share) + COB	=	Enhanced Payment Due (if > 0)	

b. If the final calculation shows that the Medicare Repriced Amount is less than or equal to the Allocated Capitation Amount, including Member Responsibility and COB/ Third-Party Liability, no enhanced payment would be due to the provider.

c. EXAMPLE

- Dr. Smith received $980 in capitation.
- She rendered service code 99215 three times, submitted on one claim.
- Total COB was $20; total cost share was $5.
- The NY Medicare/ACA Fee Schedule amount for this eligible service was $162.58.
- Based on the NY Medicare/ACA Fee Schedule, total cost for all capitated services for the six-month period January 2013 through June 2013 was $1,100.

Using these facts, the Enhanced Payment Due for this one service is calculated as follows:

$162.58	x	3	=	$487.74			
$487.74	/	$1,100	x	$980	=	$434.53	
$487.74	-	$434.53	-	($5 + $20)	=	$28.21	

I am a PCP receiving fee-for-service payments. How did Healthfirst determine the enhanced payment for FFS services?

a. Using the claims we paid for the eligible services rendered by contracted providers or qualified noncontracted providers who attested, Healthfirst calculated FFS enhanced payments using the following methodology:

NY Medicare/ACA Fee Schedule amount for eligible service	-	GREATER OF: Healthfirst FFS Contract-Allowed Amount for eligible service OR COB Amount	=	Enhanced Payment Due (if > 0)

b. If the final calculation shows that the NY Medicare/ACA Fee Schedule amount is less than either the Healthfirst payment (including Member Responsibility) or COB/ Third-Party Liability, no enhanced payment would be due to the provider.

c. EXAMPLE

- Dr. Jones received payment from a third-party primary payer for 99215, an eligible service, in the amount of $100.
- Healthfirst contract-allowed amount is $50, including member cost share. Since COB is greater than Healthfirst contract-allowed amount, Healthfirst does not pay for this service.
- The NY Medicare/ACA Fee Schedule amount for this eligible service was $162.58.

Using these facts, the Enhanced Payment Due for this one service is calculated as follows:

$162.58	-	($100 > $50 = $100)	=	$62.58

I received my enhanced payment along with my summary report, but the numbers do not match my accounting record of payments received by Healthfirst. How can I obtain details to ensure I received the correct amount?

a. Every provider will have a discrepancy between total payments received during the covered period and the enhanced payment because only certain services were eligible to receive an enhancement. Healthfirst pays for many more services than are on the list of eligible services finalized by CMS.

b. Healthfirst has a Provider Portal, accessible through our website at **www.healthfirst.org/providerservices**, where any provider, whether contracted or not, is able to create a secure account and to access claims information online. Healthfirst is in the process of finalizing detailed reports which will be available online through the portal to all providers who receive a payment.

I disagree with the enhanced payment amount I received on or after June 30, 2014, and I wish to appeal or file a reconsideration request. How can I do this?

a. Enhanced payments are not subject to contractual and regulatory appeal rights.

b. Every eligible claim was submitted to the State for reimbursement, based on specific singular payment codes identified by CMS and the State and specific eligibility criteria, which does not include every provider or every claim.

c. If you do not agree with the enhanced payment amount, please feel free to contact Provider Services at **1.866.889.2523, Monday to Friday, 9am–5pm**, where they will document your concern.

d. If Healthfirst reprocessed one of your claims at a different amount and you feel an adjustment is needed on the enhanced payment, we are aware of this, and the adjustment will be made automatically on the next quarterly submission to the State, for which you will be paid as applicable.

I am a provider who did business with Healthfirst in 2013, but I did not receive an enhanced payment on or after June 30, 2014. How can I verify whether I was supposed to get a payment or not?

a. If you did not file an attestation with NYSDOH asserting that you have performed 60% or more primary care eligible services, you are not eligible for retroactive payments to January 1, 2013.

b. Additionally, if you did file an attestation but did not receive a payment on or after June 30, 2014, then you may be included in the criteria below. These individuals or entities are not eligible for a payment:

- Designated Federally Qualified Health Center (FQHC) or certified "FQHC look-alike."
- Nurse Practitioner or other eligible Physician Extender (Advanced Practice Clinician) whose supervising physician has qualified, attested, and named you as an APC but you bill using the supervising physician's NPI.

c. If you generally meet the criteria for eligibility but still did not receive a payment, please note that only eligible services are subject to enhanced payment. If you feel you have not received payment for eligible services, please contact Provider Services at **1.866.889.2523**.

ANNUAL
Provider Update

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

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

- Healthfirst Formulary
- Healthfirst FDR and Affiliate Compliance Attestation
- Healthfirst Leaf Plan—Provider FAQs
- Healthfirst Model of Care
- Healthfirst Policy on Provider Access and Availability
- Healthfirst Personal Care Agency Quick Reference Guide
- Healthfirst Provider Manual
- Healthfirst Provider Orientation—Medicare
- Healthfirst Qualified Health Plans Quick Reference Guide
- Healthfirst Quick Reference Guide
- Healthfirst Smoking Cessation Flyer
- 2014 HEDIS QARR Quick Reference Guide—Adults
- 2014 HEDIS QARR Quick Reference Guide—Pediatrics
- Access to Medical Care for Individuals with Mobility Disabilities
- Americans with Disabilities Act Commonly Asked Questions
- Behavioral Health Providers Areas of Expertise Form
- Block Vision Authorization Form
- CDC Immunization Schedule 0–18 yrs.
- Communicable Disease Reporting Requirements
- Cultural Competence Orientation
- DME Payment Policy Phase II—January 2014
- DME Payment Policy Phase II—Policy and Examples
- Domestic Violence: Finding Safety and Support
- EFT Authorization Form
- ERA Provider Set-up Form
- FDR & Affiliate Compliance Guide
- Guide to the Compliance Program
- High-Risk Medication Reference Material
- High-Risk Medications List for Website
- IRS Form W-9
- Medicare Appointment of Representative Form
- NYC DOH Treating Tobacco Addiction
- NYS DOH Aids Institute Provider Guide to HIV Testing
- Preventing Fraud, Waste, and Abuse Through Medical Record Review
- Say Yes to the Test: Why Testing for HIV Should Become Routine in Your Practice Setting
- Say Yes to the Test Consumer Brochure

If you have any questions about the information in the Annual Update, please contact Healthfirst Provider Services at **1.888.801.1660, Monday to Friday, 9am–5pm**, or email **providerservices@healthfirst.org**.

Questionnaires Sent To Healthfirst Members

Healthfirst members receive many surveys throughout the year. These surveys assess the clinical history and health of our members, as well as the members' satisfaction with the health plan, their doctors, and overall care.

Survey Type	Administered by	Population/Frequency	Incentives	Key Measures
Medicare SNP Health Risk Assessment (LIP, MAX, Assured)	Healthfirst	Enrollment and annually	$10 Wellness Reward Card	• Overall health • Generates a care plan • Facilitates a conversation between member and M.D. • Physical health • Mental health • Physical activity • Bladder control
Medicaid Health Risk Assessment (HRA)	Healthfirst	Enrollment only	$10 Wellness Reward Card	• Overall health • Facilitates a conversation between member and M.D. • Physical health • Mental health • Physical activity
Health Questionnaire QHP (commercial product)	Healthfirst	Enrollment only	--------	• Facilitates a conversation between member and M.D. • Physical health
Health Outcomes Survey (HOS)	CMS	Randomly selected Medicare members 18 years and older (annually)	--------	• Physical health • Mental health • Physical activity • Bladder control
Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey	NYS/CMS	Medicare and Medicaid (both annually)	--------	GETTING NEEDED CARE • Ease of getting appointment, specialists, care, tests, or treatment
Member Satisfaction	Healthfirst	Medicare/Medicaid, QHP/MLTC (no less than quarterly)	--------	GETTING CARE QUICKLY • Wait times in the office • Getting care right away when the member thought it was needed COORDINATION OF CARE • Doctor has medical records of member • Doctor followed up with test results • Doctor spoke to the enrollee about prescription medicines • Whether the personal doctor is informed and up-to-date about specialist care

We want our members to experience the highest level of care and for that to be reflected in our survey scores. Because you work directly with our members, please be aware that they may ask you about the survey. Encouraging our members to complete the questionnaire will help ensure they are getting the care they need, which in turn will also help Healthfirst raise our quality scores.

The September 2014 NYS CAHPS survey is focused on members with children.

If you would like to improve your scores and to look for ways to enhance the member experience, please contact your network representative. We can provide recommendations on how to improve member access/scheduling, coordination of care between providers, and overall customer service satisfaction.

Tips to Improve Communication with Your Patients

Maintaining open and honest communication with your patients is essential to establishing a good doctor/patient relationship. It impacts better health, adherence to treatment programs, and greater satisfaction with the care patients receive. Below are tips to help you communicate effectively with your Healthfirst members during their next office visit:

- Make eye contact to establish a personal connection.
- Use welcoming words and an even tone of voice.
- Speak slowly and clearly.
- Ask direct questions to gain insight.
- Be empathetic.
- Instead of using medical jargon, communicate to your patients in language they understand and break down clinical information into common terms.
- Listen without interrupting to what your patient is saying.
- Stick to one topic at a time.
- Frequently summarize the most important points of the visit. Ask your patients to repeat your instructions so that you can confirm that they understand.
- Spend time talking with patients about medications. Review your patients' medication list to make sure they understand the reason that they take each one.
- Manage your patients' expectations. Help them understand next steps in their treatment and possible outcomes.
- Ask your patients to explain how they will undertake a recommended treatment or intervention.
- Review the patients' chart before starting the visit.
- Allow extra time for new and elderly patients.
- Be visual. Some patients respond better to visual images. Use charts, pictures, and models to reinforce your point.

With your pediatric patients, it is also very important to establish a rapport, create opportunities to help them express their concerns, and answer their questions. In addition to the previously listed tips, the following strategies may be used to engage children during an office visit:

- Speak with the child, not at or to him/her.
- Begin with a nonthreatening topic.
- Listen actively.
- Pay attention to body language and tone of voice.
- Use drawings, games, or other creative communication tools.
- Ask the child what he/she would do with three wishes or a magic wand.

Following an office visit, it is important to maintain active communication with your patients by:

- Sending reminders regarding missing services such as preventive care, vaccinations, or screening tests.
- Being timely with follow-up calls to patients, allowing time for questions.
- Applying technology to enhance communication interaction.
  - Electronic Health Records (EHR) provides patients access to their records, including lab and educational resources. But it may also encourage dialogue and have a positive effect, according to *The Journal of the American Medical Association*.
  - Other studies have also shown that patients appreciate access to the data in their EHR. This can boost loyalty and improve patient safety.
  - If you have a patient-portal, educate your patients on ease of use to access lab results and other information (diagnosis, medications, immunizations, and procedures). Train your staff to educate patients on how to use the portal as well.

Sources:

American Academy of Family Physicians, www.aafp.org; Medscape, www.medscape.org; Pediatrics, Official Journal of the American Academy of Pediatrics, 2008; 121; e1441; www.fierceemr.com/story/ehrs-can-improve-patient-physician-interaction/2013-06-19.

Restructuring of the Quality Improvement Organization Program

The Centers for Medicare & Medicaid Services (CMS) is restructuring the Quality Improvement Organization (QIO) program to improve both patient care and health outcomes, and saving taxpayer resources. The overall restructuring of the QIO program will allow for the creation of Beneficiary and Family-Centered Care Quality Improvement Organizations (BFCC-QIOs) contractors to support the program in five service areas. As of August 1, 2014, Livanta conducts all beneficiary quality review cases, appeals, and complaints for Service Area 1, which includes New York and New Jersey. These changes are part of the CMS QIO program transformation effort. Livanta will replace the current QIOs in New York (IPRO) and New Jersey (HQSI).

QIOs review medical records to determine whether services delivered to Medicare beneficiaries meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting. Additionally, in an effort to promote measurable improvement in beneficiary health status or satisfaction, QIOs review written complaints from beneficiaries about the quality of Medicare services they have received.

What has changed in the QIO program?

CMS has separated medical case review from quality improvement work. The same organization/contractor cannot hold both types of medical case review and quality improvement contracts. The restructuring includes:

- Medical case review – BFCC-QIOs will conduct quality of care reviews, including utilization reviews, discharge and termination of service appeals, and beneficiary complaints.
- Quality improvement and technical support – Quality Innovation Network QIOs (QIN-QIOs) will work with providers on quality initiatives to improve patient safety, reduce harm, and improve clinical care and transparency.

Which QIO will handle Medicare case reviews?

Livanta BFCC-QIO began case review work on August 1, 2014.

Which QIO will handle quality improvement and technical assistance work?

CMS has not yet announced the QIN-QIO contractor awards.

The QIN-QIOs will be responsible for working with providers and the community on multiple data-driven quality initiatives to improve patient safety, reduce harm, and improve clinical care at their local and regional levels. Quality improvement initiatives will also be developed from BFCC-QIO tracking and trending of beneficiary quality-of-care reviews.

How will this change affect your facility?

Your QIO contact information for Medicare coverage and discharge appeals, as well as for quality-of-care concerns, will be the Livanta BFCC-QIO.

What is the new contact information for the Livanta BFCC-QIO?

- Toll-free telephone number is 1.866.815.5440.
- TTY number is 1.866.868.2289.
- Fax number for Appeals is 1.855.236.2423.
- Fax number for All Other Reviews is 1.844.420.6671.
- The address for mailing hard-copy medical records, effective August 1, 2014, or later, is:
  BFCC-QIO Program
  9090 Junction Drive, Suite 10
  Annapolis Junction, MD 20701

Please update all contact references, address books, and beneficiary forms to reflect contact information for the Livanta BFCC-QIO, including:

- *"An Important Message from Medicare about your Rights"* forms, which inform beneficiaries of their rights to appeal a discharge decision.
- *"Notice of Medicare Non-Coverage"* forms for hospitals with swing beds.
- Print and electronic copies of beneficiary resources that include the QIO's contact information.
- Policies and procedures containing QIO contact information.

What will not change?

As the BFCC-QIO, Livanta will continue to protect beneficiaries by promoting health improvement strategies through quality-of-care reviews, beneficiary complaints reviews, discharge and termination of service appeals in various provider settings, medical necessity, and Emergency Medical Treatment and Active Labor Act (EMTALA) reviews.

May I send medical records to Livanta electronically?

CMS plans to have a secure file platform for providers to submit QIO-requested medical records via the Internet.

Source:

www.bfccqioarea1.com/provider.html.

Adult Immunization Standards

The Standards for Adult Immunization Practice Guidance describes the following four steps that every provider should implement when seeing adult patients:

1. Incorporate immunization needs assessment into every clinical encounter.
2. Strongly recommend needed vaccine(s) and either administer vaccine(s) or refer patient to a provider who can immunize.
3. Stay up-to-date on, and educate patients about, vaccine recommendations.
4. Implement systems to incorporate vaccine assessment into routine clinical care. Understand how to access immunization information systems (i.e., NYC Citywide Immunization Registry).

Resources to implement these standards, including information sheets for distribution to patients and provider scripts for talking about immunizations with adult patients, are available from the Centers for Disease Control and Prevention at **www.cdc.gov/vaccines/hcp/patient-ed/adults/for-practice/standards/index.html**, and from the National Adult and Influenza Immunization Summit website at **www.izsummitpartners.org/adult-immunization-standards**.

Sources:

www.publichealthreports.org/issueopen.cfm?articleID=3145; www.nyc.gov/html/doh/downloads/pdf/imm/adult-immunization-practice-ltr.pdf.

HEDIS 2015 Requirements for Cancer Screenings

BREAST CANCER SCREENING (BCS) **Women 50–74 years old should have a mammogram every 1–2 years**	
CPT-4: 77055–77057	ICD-9 Procedure: 87.36, 87.37
CERVICAL CANCER SCREENING (CCS) **Women 21–64 years old should be screened for cervical cancer using either of the following:** **21–64 years old—cervical cytology every 1–3 years** **30–64 years old—cervical cytology with HPV co-testing every 1–5 years**	
Cervical Cytology	
CPT-4: 88141–88143, 88147, 88148, 88150, 88152–88154, 88164–88167, 88174, 88175	
HPV Test	
CPT-4: 87620–87622	
COLORECTAL CANCER SCREENING (COL) **Adults 50–75 years old should be screened for colorectal cancer by one of the following:**	
Fecal occult blood test (FOBT, gFOBT, iFOBT) every year	
CPT-4: 82270, 82274	
Flexible sigmoidoscopy during the measurement year or 4 years prior	
CPT-4: 45330–45335, 45337–45342, 45345	ICD-9 Procedure: 45.24
Colonoscopy during the measurement year or 9 years prior	
CPT-4: 44388–44394, 44397, 45355, 45378–45387, 45391, 45392	ICD-9 Procedure: 45.22, 45.23, 45.25, 45.42, 45.43
NON-RECOMMENDED PROSTATE-SPECIFIC ANTIGEN-BASED SCREENING IN OLDER MEN (PSA)—New HEDIS measure **Men 70 years or older should not receive a PSA-based screening if they are not at high risk for prostate cancer**	

New York State Immunization Updates for the 2014-2015 School Year

As of July 1, 2014, the New York State Department of Health (DOH) revised the immunization requirements for school attendance to be consistent with the most current childhood and adolescent immunization recommendations made by the Advisory Committee on Immunization Practices (ACIP). The updated requirements do not add any new vaccines for school entry but do update the number of doses required and the minimum intervals between doses.

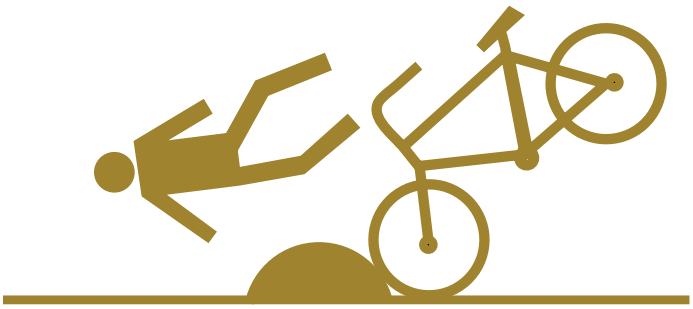
The new requirements, which apply to daycare, Head Start, nursery, pre-kindergarten, and grades K-12, represent the continued effort to protect students from vaccine-preventable diseases. The changes mark the first update to school immunization requirements in over a decade and include:

- Students entering kindergarten or 6th grade in the 2014-2015 school year will now be required to have **two doses of the varicella (chickenpox) vaccine** and **3-5 doses of poliomyelitis vaccine**. The updated varicella and polio vaccination requirements will be phased in over the next seven years and will be required for all grades by the 2020-2021 school year.
- For all other required vaccines, students in daycare, Head Start, nursery, pre-kindergarten, and grades K-12 will be required to have **age-appropriate doses**, in accordance with the ACIP schedule.
- A **student who is in process** is defined as one who has had the first dose of a vaccine in all of the required immunization series and has appointments to complete the series in accordance with the ACIP catch-up schedule **(www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html)**. A student who is in process must be allowed to attend school.
- Students may present **proof of immunity by serology** (blood test) for the following immunizations: measles, mumps, rubella, hepatitis B, varicella, and poliomyelitis.
- **Medical exemptions** to immunizations must be reissued **annually**. The written exemption must identify the immunization exempted, the medical contraindication for the exemption, and the length of time the immunization is contraindicated. A sample medical exemption form is available at **www.health.ny.gov/prevention/immunization/schools**.
- Any child who has been vaccinated according to the ACIP recommendations, which are followed by most healthcare providers, should not need further vaccinations in order to attend daycare or school.

More detailed information—including an immunization chart outlining the new requirements for the 2014-2015 school year, frequently asked questions regarding the school immunization regulations, and a webinar presented by DOH staff reviewing the updated school immunization regulations—is available at the DOH's Immunization website: **www.health.ny.gov/prevention/immunization/schools/updated_school_imm_requirements.htm**.

Source:

www.health.ny.gov/press/releases/2014/2014-07-01_school_immunization_requirements.htm.



Injury Prevention in New York State

Injuries are the leading cause of death for New Yorkers aged one through 44 years and a leading cause of death for all other New Yorkers. More than 7,250 New Yorkers die each year because of injury. Injuries occur in predictable patterns, with recognizable risk factors, and among identifiable populations.

Injury Prevention for All New Yorkers

Bicycle and Other Wheeled Recreation Safety (www.health.ny.gov/prevention/injury_prevention/bicycles.htm)

Bicycle Helmet Law: By law, all bicyclists under the age of 14 are required to wear approved bicycle helmets when bicycling or riding as passengers on bicycles in New York State. The maximum penalty for an offense is a $50 fine. However, if a parent can prove that a helmet has been obtained, the fine will be waived.

Consider the following facts

- Each year, about 54 New York State residents are killed in bicycle crashes.
- Each year, about 2,000 New York State residents are hospitalized due to bicycle-related injuries. Of these hospitalizations, approximately 38 percent involve a brain injury.
- Head injury is the leading cause of death and permanent disability in bicycle crashes. Head injuries account for more than 60 percent of bicycle-related deaths, more than two-thirds of bicycle-related hospital admissions, and about one-third of hospital emergency department visits for bicycling injuries.

Why wear helmets?

- Professional and amateur athletes in many sports wear helmets. Football, hockey, and even baseball players wear helmets. Cyclists need protection for the special risks they face, too.
- Brain injuries are usually the most serious injuries a bicycle rider will sustain. Helmets prevent many of these injuries or reduce their severity.
- Studies in the U.S. and elsewhere have shown that bike riders wearing helmets are less likely to suffer brain injuries than those who don't.
- Bicycles, even when in the hands of young children, can be rapidly moving vehicles, easily reaching speeds of 20 miles per hour or more.
- Compared to the dollar and human cost of brain injuries, helmets are inexpensive insurance.

Injury Prevention for Children

Injuries are the leading cause of death for children in New York State. In addition, injuries result in an average of over 18,000 hospitalizations among New York children 19 and younger. Through various avenues—the *"Injury-Free Kids!"* campaign, traumatic brain injury prevention, shaken baby syndrome prevention, choking prevention, poison prevention, child passenger safety, teen driving, and pedestrian safety programs—the New York State Department of Health is helping parents and caregivers make children's lives safer.

Injury Prevention for Adults

STEADI (Stopping Elderly Accidents, Deaths & Injuries) Tool Kit for Healthcare Providers

Did you realize that one out of three people 65 and older fall each year? The good news is that healthcare providers can help reduce their patients' chances of falling and suffering serious injuries like hip fractures and traumatic brain damage.

CDC's Injury Center created the STEADI Tool Kit for healthcare providers who, in their practice, see older adults who are at risk of falling or who may have fallen in the past. The STEADI Tool Kit gives healthcare providers the information and tools they need to assess and address their older patients' fall risk.

STEADI Tool Kit and resources available at: **www.cdc.gov/homeandrecreationalsafety/Falls/steadi/index.html**.

Reducing the Risk of Lead Poisoning

Lead Prevention Guidelines:

- Test all children at age **one year** and again at **age two** with a blood lead test.
- Assess all children **ages six months to six years at every well-child visit** for risk of lead exposure (use assessment questions below) and obtain a blood lead test if there is a positive response to any of the questions.
- Provide **anticipatory guidance** to all parents of children less than six years old as part of routine care. Use parent handout, *"What Your Child's Blood Lead Test Means"* **(www.health.ny.gov/publications/2526/)**.
- Test **all foreign-born children up to age 16 years**, particularly refugee and internationally adopted children, upon arrival in the U.S. and again three to six months after they obtain permanent residency.
- Test children of any age if lead exposure is suspected. All children found to have elevated blood lead levels, regardless of age, require **follow-up services**.

Risk Assessment Questions for Children Less Than Six Years Old:

1. **Does your child live in or regularly visit an older home/building with peeling or chipping paint, or with recent or ongoing renovation or remodeling?** New York City banned lead-based paint for residential use in 1960. In 1977, the U.S. Consumer Product Safety Commission banned the use of lead-based paint in residential buildings. Older dwellings may have lead-based paint under new paint. Consider daycare, preschool, school, and home of babysitter or relative. Ask if any move, repair, or renovation is planned and provide anticipatory guidance if needed. Children with Medicaid, those entering foster care, and recently arrived refugees are more likely to live in older, poorly maintained housing and to have higher rates of lead poisoning.
2. **Has your child spent any time outside the U.S. in the past year?** All foreign-born children should be tested upon arrival in the U.S., due to the higher lead risk in many foreign countries.
3. **Does your child have a brother/sister, housemate/playmate being followed or treated for lead poisoning?**
4. **Does your child eat non-food items (pica)?** Does your child often put things in his/her mouth such as toys, jewelry, or keys? Children with developmental disabilities are at higher risk for pica. Product recall information is available at **www.cpsc.gov**.
5. **Does your child often come into contact with an adult whose job or hobby involves exposure to lead?** Some examples are: house painting, plumbing, renovation, construction, auto repair, welding, electronics repair, battery recycling, lead smelting; jewelry, stained glass, or pottery making; fishing (weights); making or shooting firearms; or collecting lead or pewter figurines.
6. **Does your family use traditional medicine, health remedies, cosmetics, powders, spices, or food from other countries?** Lead has been found in items such as: Ayurvedic medicines, al kohl, azarcon (alarcon, luiga, rueda, coral), greta, litargirio, ghasard, pay-loo-ah, bala goli, Daw Tway, Daw Kyin; cosmetics such as kohl, surma, and sindoor; and some candies and other products from Mexico. More information available at: **www.cdc.gov/nceh/lead/tips/sources.htm**.
7. **Does your family cook, store, or serve food in leaded crystal, pewter, or pottery from Asia or Latin America?** Lead exposure risk from pottery is higher with old, cracked/chipped, and painted china; low-fired or terra cotta pottery from Latin America or the Middle East; and imported samovars, urns, and kettles.

For more information on lead poisoning prevention, educational materials, clinical tools, and resources, visit **www.healthfirst.org**.

Source:

www.health.ny.gov/publications/2501/.

Nutrition Recommendations for Diabetics

Strategies for all people with diabetes:

- Portion control should be recommended for weight loss and maintenance.
- Carbohydrate-containing foods and beverages and endogenous insulin production are the greatest determinant of the post-meal blood glucose level; therefore, it is important to know which foods contain carbohydrates—starchy vegetables, whole grains, fruit, milk and milk products, vegetables, and sugar.
- When choosing carbohydrate-containing foods, choose nutrient-dense, high-fiber foods whenever possible instead of processed foods with added sodium, fat, and sugars. Nutrient-dense foods and beverages provide vitamins, minerals, and other healthful substances with relatively few calories. Calories have not been added to them from solid fats, sugars, or refined starches.
- Avoid sugar-sweetened beverages.
- For most people, it is not necessary to subtract the amount of dietary fiber or sugar alcohols from total carbohydrates when carbohydrate counting.
- Substitute foods higher in unsaturated fat (liquid oils) for foods higher in trans or saturated fat.
- Select leaner protein sources and meat alternatives.
- Using vitamin and mineral supplements, herbal products, or cinnamon to manage diabetes is not recommended, due to lack of evidence.
- Moderate alcohol consumption (one drink a day or less for adult women and two drinks a day or less for adult men) has minimal acute or long-term effects on blood glucose in people with diabetes. To reduce risk of hypoglycemia for individuals using insulin or insulin Secretagogues, alcohol should be consumed with food.
- Limit sodium intake to 2,300 mg/day.

Priority should be given to coordinating food with type of diabetes medicine for those individuals on medicine.

- For individuals who take insulin Secretagogues:
  - Moderate amounts of carbohydrates at each meal and snack.
  - To reduce risk of hypoglycemia:
    - Eat a source of carbohydrates at meals.
    - Moderate amounts of carbohydrates at each meal and snack.
    - Do not skip meals.
    - Physical activity may result in low blood glucose, depending on when it is performed. Always carry a source of carbohydrates to reduce risk of hypoglycemia.

- For individuals who take Biguanides (Metformin):
  - Gradually titrate to minimize gastrointestinal side effects when initiating use.
    - Take medication with food or 15 minutes after a meal if symptoms persist.
    - If side effects do not resolve over time (a few weeks), follow up with healthcare provider.
    - If taking along with an insulin Secretagogue or insulin, hypoglycemia may be experienced.
- For individuals who take α-Glucosidase inhibitors:
  - Gradually titrate to minimize gastrointestinal side effects when initiating use.
  - Take at start of meal for maximal effect.
    - If taking along with an insulin Secretagogue or insulin, hypoglycemia may be experienced.
    - If hypoglycemia occurs, eat something containing monosaccharides, such as glucose tablets, as drug will prevent the digestion of polysaccharides
- For individuals who take Incretin Mimetics (Glucagon-like Peptide-1):
  - Gradually titrate to minimize gastrointestinal side effects when initiating use.
    - Injection of daily or twice-daily Glucagon-like Peptide-1s (GLP-1s) should be pre-meal.
    - If side effects do not resolve over time (a few weeks), follow up with healthcare provider.
    - If taking along with an insulin Secretagogue or insulin, hypoglycemia may be experienced.
    - Once-weekly GLP-1s can be taken at any time during the day, regardless of meal times.
- For individuals with type 1 diabetes and insulin-requiring type 2 diabetes:
  - Learn how to count carbohydrates or use another meal planning approach to quantify carbohydrate intake. The objective of using such a meal planning approach is to "match" mealtime insulin to carbohydrates consumed.
  - If on a multiple-daily injection plan or on an insulin pump:
    - Take mealtime insulin before eating.
    - Meals can be consumed at different times.
    - If physical activity is performed within 1-2 hours of mealtime insulin injection, this dose may need to be lowered to reduce risk of hypoglycemia.
  - If on a premixed insulin plan:
    - Insulin doses need to be taken at consistent times every day.
    - Meals need to be consumed at similar times every day.
    - Do not skip meals. Skipping meals increases risk of hypoglycemia.
    - Physical activity may result in low blood glucose, depending on when it is performed. Always carry a source of quick-acting carbohydrates to reduce risk of hypoglycemia.
  - If on a fixed insulin plan:
    - Eat similar amounts of carbohydrates each day to match the set doses of insulin.

Source:

Evert AB, Boucher JL, Cypress M, et al. Nutrition therapy recommendations for the management of adults with diabetes. Diabetes Care. 2013;36:3821–3842.

Nutrition and Physical Activity

Nutrition

Health professionals recognize the benefits associated with a healthful eating plan based on the Dietary Guidelines for Americans, including:

- Decreased risk of chronic diseases, such as type 2 diabetes, hypertension, and certain cancers.
- Decreased risk of being overweight or obese.
- Decreased risk of micronutrient deficiencies.

While most members already know it is important to eat a healthy diet, they may find it more difficult to sort through all of the information about nutrition and food choices. A variety of resources are available to help start healthier eating habits.

Choosemyplate.gov features practical information and tips to help Americans build healthier diets:

- **www.cdc.gov/nutrition/everyone/index.html**
- **www.choosemyplate.gov/**

The Benefits of Physical Activity

Physicians should educate members that regular physical activity is one of the most important things members can do for their health. It can help:

- Control your weight **(www.cdc.gov/physicalactivity/everyone/health/index.html#ControlWeight)**
- Reduce your risk of cardiovascular disease **(www.cdc.gov/physicalactivity/everyone/health/index.html#ReduceCardiovascularDisease)**
- Reduce your risk for type 2 diabetes and metabolic syndrome **(www.cdc.gov/physicalactivity/everyone/health/index.html#ReduceDiabetes)**
- Reduce your risk of some cancers **(www.cdc.gov/physicalactivity/everyone/health/index.html#ReduceCancer)**
- Strengthen your bones and muscles **(www.cdc.gov/physicalactivity/everyone/health/index.html#StrengthenBonesMuscle)**
- Improve your mental health and mood **(www.cdc.gov/physicalactivity/everyone/health/index.html#ImproveMentalHealth)**
- Improve your ability to do daily activities and prevent falls, if you're an older adult **(www.cdc.gov/physicalactivity/everyone/health/index.html#PreventFalls)**
- Increase your chances of living longer **(www.cdc.gov/physicalactivity/everyone/health/index.html#LiveLonger)**

Remind members: If you're not sure about becoming active or boosting your level of physical activity because you're afraid of getting hurt, the good news is that **moderate-intensity aerobic activity**, like brisk walking, is generally **safe for most people**.

Physical Activity for Children/Providers Can Encourage Parents

What can I do to get—and keep—my child active? As a parent, you can help shape your child's attitudes and behaviors toward physical activity, and knowing these guidelines is a great place to start. Throughout their lives, encourage young people to be physically active for one hour or more each day, with activities ranging from informal, active play to organized sports. Here are some ways you can do this:

- Set a positive example by leading an active lifestyle yourself.
- Make physical activity part of your family's daily routine by taking family walks or playing active games together.
- Give your children equipment that encourages physical activity.
- Take young people to places where they can be active, such as public parks, community baseball fields, or basketball courts.
- Be positive about the physical activities in which your child participates and encourage them to be interested in new activities.
- Make physical activity fun. Fun activities can be anything your child enjoys, either structured or nonstructured. Activities can range from team sports or individual sports to recreational activities such as walking, running, skating, bicycling, swimming, playground activities, or free-time play.
- Instead of watching television after dinner, encourage your child to find fun activities to do on their own or with friends and family, such as walking, playing chase, or riding bikes.
- Be safe! Always provide protective equipment such as helmets, wrist pads, or knee pads and ensure that activity is age-appropriate.

Sources:

www.cdc.gov/nutrition/professionals/index.html; www.cdc.gov/physicalactivity/everyone/health/index.html; www.cdc.gov/physicalactivity/everyone/getactive/children.html.

Oral Health Recommendations for All Ages

Many New Yorkers do not receive proper oral healthcare. In New York City, about one in four (23%) children and more than one in three (37%) adults have not had a preventive dental visit in the past year. More than one-third (38%) of third grade children have untreated cavities, and 25% of adults ages 65 and older have had all their permanent teeth extracted. [2, 3]

Healthfirst encourages you to integrate oral health into your medical practice to help prevent dental problems and improve oral healthcare access for our members by adhering to the recommendations below:

- Educate patients about preventive oral healthcare including **annual dental visits**, fluoride varnish, and dental sealants.
- **Refer children to a dentist by age one** and ask about each patient's most recent dental visit.
- Receive training to provide brief **oral health screenings** and application of **fluoride varnish**. For more information about fluoride varnish, visit **www.nyc.gov/html/doh/downloads/pdf/hca/hca-ask-fluoride-varnish.pdf**.
- Advise **pregnant women** to discuss dental care during pregnancy with their prenatal care provider.
- Instruct patients to **drink tap water** instead of sugar-sweetened beverages and to cut down on sugary snacks. Parents should reduce or **eliminate sugar-sweetened beverages** and juice in baby bottles and sippy cups, especially at night and between meals.
- Provide **smoking cessation** counseling and inform the patient to call 311 or visit **www.nycquits.org** for additional help.
- Reinforce the need to **limit alcohol use** and have the patient call 311 or LifeNet **(1.800.543.3638)** for support.
- **Encourage members to brush teeth twice daily** with a toothpaste containing fluoride, to clean between the teeth with dental floss, and to use mouth rinse. For brushing recommendations for children, visit: **www.aapd.org**.

For general information from the American Dental Association (ADA), visit **www.ada.org/2624.aspx** or check out **www.healthfirst.org** to obtain educational materials, clinical tools, and resources.

Sources:

Hosseinipour N, Jasek J, and Summers C. Oral Health in New York City. NYC Vital Signs 2012, 11(5); 1–4.

[2] New York State Department of Health. Oral Health Indicators-New York County 2002–2004.

[3] New York State Department of Health. Expanded Behavioral Risk Factor Surveillance System: Final Report July 2008–June 2009. Available at www.health.ny.gov/statistics/brfss/expanded/2009/county/docs/new_york_state_exclusive_of_new_york_city_new_york_city_new_york_state.pdf.

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