The Source

Winter 2013

healthfirst®

IN THIS ISSUE

CONTACTS

Medical Management & Behavioral Health Unit
1.888.394.4327
Monday–Friday, 8:30am–5:30pm

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, FHP, Medicaid
1.866.463.6743
Monday–Friday, 8:00am–6:00pm

Member Services: Medicare
1.888.260.1010
Monday–Friday, 8:00am–8:00pm

Produced by:
Healthfirst
Marketing & Communications

From the Desk of the
Chief Medical Officer

Dear Valued Provider,

As I look back on 2013 and peer into 2014, I am struck by the historic change that is impacting providers and plans alike, a change unlike any we've seen in our profession in nearly a half century.

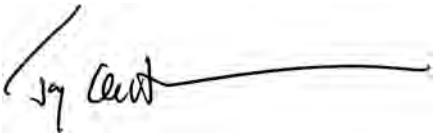
State and Federal Health Exchanges across our nation have begun enrolling members. Closer to home, Healthfirst has begun marketing our Qualified Health Plans through the *New York State of Health: The Official Health Plan Marketplace*. We have worked diligently to prepare for this moment, and with only a few weeks to go until the January 1, 2014 start date, we have seen considerable interest in these plans. We have included an informative FAQ on pages 4 and 5 that should answer many of your questions.

The law that gave rise to Health Exchanges, known as the Patient Protection and Affordable Care Act, also placed a greater emphasis on providing quality care. The best-known gauge for quality is the Medicare Stars program, in which CMS rates the overall quality of all Medicare Advantage Plans by assigning them a score of 1 to 5 stars. I am very proud to announce that Healthfirst recently raised our score from 3 to 3.5 stars, placing us at or above the level of many of our regional competitors. Improving our star rating has been a priority for Healthfirst, and credit must go to the providers and hospitals that collaborated with us on several initiatives.

As part of Healthfirst's efforts to make our company more competitive, we have taken a close look at our operations and markets. In the last issue of *The Source*, I told you about Healthfirst's acquisition of Neighborhood Health Providers, a move that further cemented our position as the top PHSP plan in our service area. In September we reached an agreement with WellCare for them to acquire the assets of Healthfirst NJ. This transaction, which is currently undergoing review by state and federal regulators and is expected to close by the end of the year, will have no impact on our New York provider network.

We are very proud of this issue of *The Source*, and continuously seek to provide content that is useful to you and your practice. We have several stories focused on managing members with chronic illnesses such as asthma and arthritis, and articles highlighting coding and payment, including stories on ICD-10 and our updated provider manual.

Thank you for being a part of our network and providing quality care to our members. Until next time,



Jay Schechtman, M.D., M.B.A.
Senior Vice President
Chief Medical Officer

ARTHRITIS FOUNDATION®

"WALK WITH EASE"

Helping Healthfirst members get stronger and feel better

For the millions of people affected by arthritis, physical activity and exercise can often be painful.

To help those with arthritis, Healthfirst collaborated with the Arthritis Foundation to educate and motivate members to improve their flexibility and strength, reduce pain, and forge new friendships.

In partnership with Bronx-Lebanon Hospital Center, Brownsville Multi-Service Family Health Center, the Chinese American Independent Physician Association (CAIPA), St. Barnabas Hospital, and SUNY Downstate Medical Center, Healthfirst members participated in the *Arthritis Basics for Change* workshop and *Walk With Ease* program. These were held at community organizations in neighborhoods where our members reside.

The *Arthritis Basics for Change* workshop educated Healthfirst members on types of arthritis, ways to prevent and decrease arthritis-related pain, and how to improve their functional levels by learning and practicing self-help techniques. Members who attended the workshop continued with *Walk With Ease*, a six-week community-based physical activity and self-management program. Led by an Arthritis Foundation trained instructor, *Walk With Ease* is a multicomponent program that includes health education, stretching and strengthening exercises, and motivational strategies. Healthfirst members also received a *Walk With Ease* Guidebook that provides information, support, and tools needed to help them set and reach their goals.

During the workshops, our hospital partners provided free health screenings and educational resources.

Your patients may visit **www.arthritis.org** to learn more about the different types of arthritis. They can also view step-by-step instructions for warming up, basic stretches, additional stretches, and strengthening exercises that will help with their walking program.

Participants practice their stretching exercises at the Ling Sing Association in Chinatown.

Starting their session with warm-up stretching exercises at the William Hodson Senior Center in the Bronx.

Exercise is a valuable tool in the fight against arthritis.

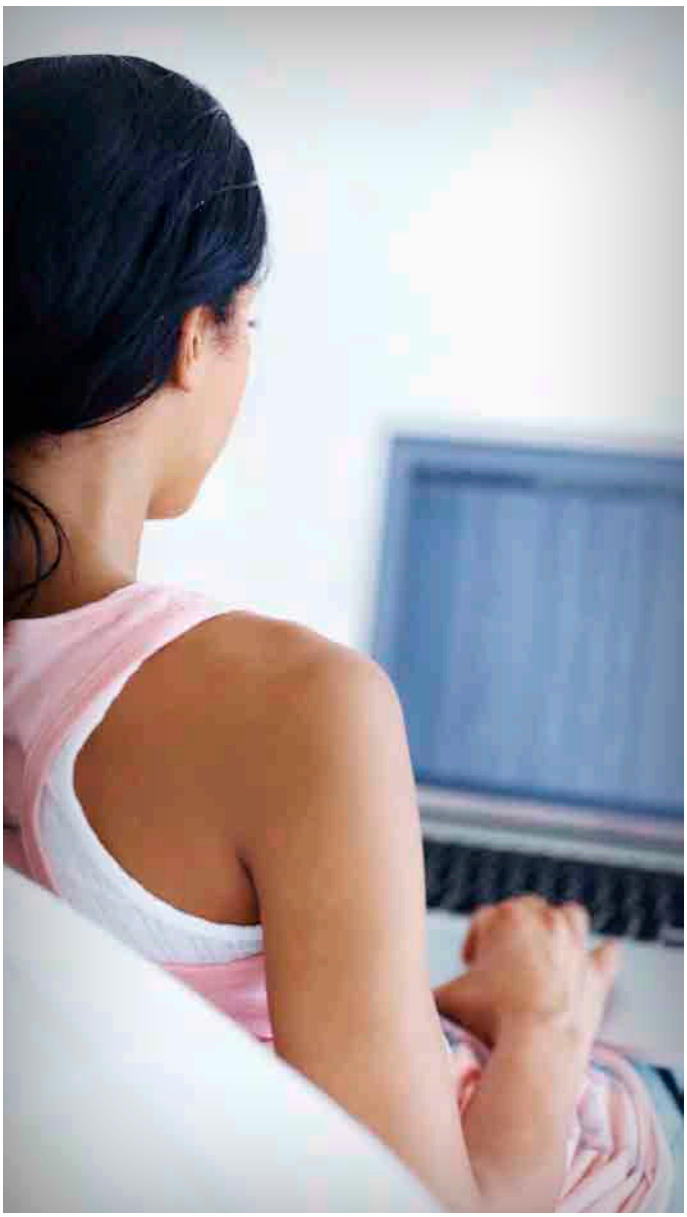
- According to the U.S. Department of Health and Human Services, there is strong evidence that both endurance and resistance types of exercise provide considerable disease-specific benefits for people with osteoarthritis (OA) and rheumatic conditions.
- A growing body of research indicates that exercise, weight management, and the avoidance of joint injury can go a long way in helping to prevent OA.
- Every pound of weight lost results in four pounds of pressure taken off each knee

Source: Arthritis Foundation, www.arthritis.org

What you need to know about

Healthfirst and the New York State of Health

As you know, the Affordable Care Act (ACA) is a federal law that is changing the US health system. It requires everyone (with very few exemptions) to have health insurance starting January 1, 2014, or pay a penalty at tax time. In the first year, an adult could face a penalty of $95 or 1% of income, whichever is higher. The amount of the penalty will increase in future years.



What do you need to know?

Since October 1, eligible New Yorkers have been able to go to the *New York State of Health: The Official Health Plan Marketplace* for a "one-stop shopping" experience. The *New York State of Health* enables consumers to compare health insurance options, calculate costs (including premiums and potential subsidies), gain awareness of public programs, and obtain assistance in selecting coverage.

More about New York State of Health: The Official Health Plan Marketplace

- It is a New York State-run organization that partners with insurance companies like Healthfirst to offer health insurance to individuals and small-business owners
- It offers federal tax credits to individuals and families to lower health insurance costs
- It is mainly for people who are under 65, live in New York, are uninsured or underinsured, and do not receive affordable insurance through a job
- Access to public health insurance—Medicaid and Child Health Plus—will be available through this marketplace, too. In 2014, new Medicaid and Child Health Plus enrollees will be able to apply and recertify through the *New York State of Health* website

Healthfirst Leaf Plans are here

We have created a portfolio of affordable health plans—called *Healthfirst Leaf Plans*—that are available on the *New York State of Health*. *Healthfirst Leaf Plans* provide affordable health coverage options for those who earn too much to qualify for a public option such as Medicaid. Each of our *Healthfirst Leaf Plans* offers essential health benefits, including checkups, maternity care, emergency services, hospitalization, prescription drugs, lab work, and more.

Open enrollment for the *Healthfirst Leaf Plans* began on October 1 and ends March 31, 2014. As of October 1, uninsured and underinsured patients have been able to enroll in one of our comprehensive healthcare plans:

- **Healthfirst Platinum Leaf**—covers 90% of healthcare expenses, with no annual deductible and low copays
- **Healthfirst Gold Leaf**—covers 80% of healthcare expenses, with a $600 annual deductible and modest copays
- **Healthfirst Silver Leaf**—covers 70% of healthcare expenses; up to $2,000 deductible and copays are based on annual income
- **Healthfirst Bronze Leaf**—covers 60% of healthcare expenses, with a $3,000 deductible
- **Healthfirst Green Leaf**—a catastrophic coverage plan for people younger than 30

Why Healthfirst?

Healthfirst is a not-for-profit, hospital-owned health plan that has been providing health coverage to underserved New Yorkers for over 20 years. We have an excellent track record of providing high-quality healthcare at a reasonable cost. Ninety-five percent of current Healthfirst members would recommend us to family and friends.[1]

In addition to the bundle of "Essential Health Benefits" mandated by the ACA, we offer our members reimbursements for gym memberships, access to over 24,000 providers, member services representatives who speak many languages, and community offices right in their neighborhood.

Healthfirst can help your patients find the health coverage that works best for them and for their families. We can help in person, by phone, and online. Healthfirst can even walk them through the application process.

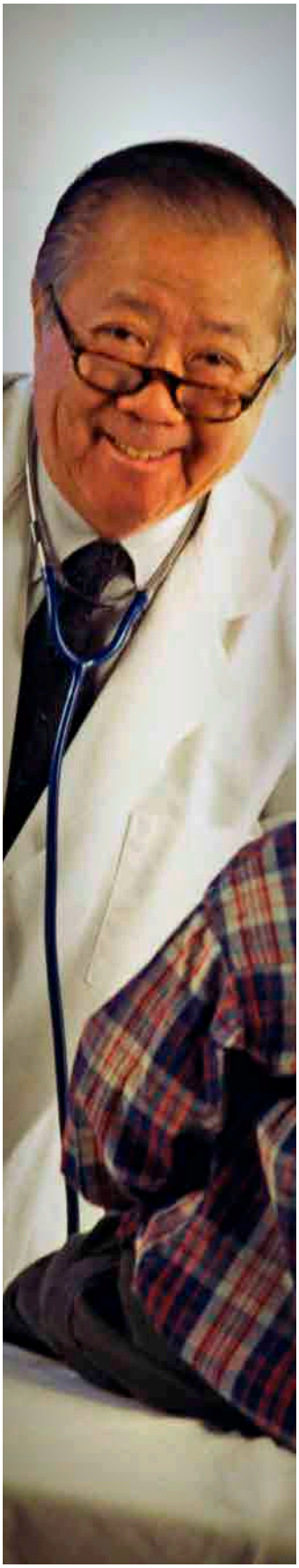
Your patients may contact us by

- Going to **www.joinhealthfirst.org** and submitting their contact information
- Calling **1.888.250.2220, Monday through Friday, 8am to 8pm,** to request an appointment with one of our representatives. We can even schedule appointments with your patients in many convenient locations, including their home or workplace
- Going to one of our community offices, located throughout NYC and in Nassau County

Providers may also visit **www.hfrefer.com** and fill out the online form for their uninsured or underinsured patients. Healthfirst will take care of the rest.

In addition to visiting the Healthfirst website, we encourage all of our providers to visit our Provider Portal, where you can obtain additional information and videos on the *New York State of Health,* the *Healthfirst Leaf Plans,* Enrollment and Eligibility, Network Referrals, Authorizations, Reimbursement and more. Please refer to the following section of the Provider Portal to learn more: NY Provider Information > New York State of Health.

For additional questions, please feel free to call our Provider Services department at **1.888.801.1660** (Monday–Friday, 9am–5pm), or your Healthfirst Network Management Representative.



[1] Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey, Feb. 2012.

Updates to New York State-sponsored programs offered through Healthfirst

Important changes that will impact you and your patients

Effective December 31, 2013, New York State will discontinue new member enrollment for the Family Health Plus (FHP) program. Existing members may renew into the program up until March 31, 2014 and can have continued coverage until December 31, 2014. Thereafter, members will need to re-enroll through the *New York State of Health*, the state's new health benefit marketplace. The FHP program will end on December 31, 2014. There will not be any members left in FHP after December 31, 2014.

New Options for Family Health Plus Members

Starting January 1, 2014, Healthfirst members who are impacted will be able to select a *Healthfirst Leaf Plans* through the *New York State of Health* or enroll in our Healthfirst Medicaid Managed Care program. Eligibility for Medicaid coverage is based on income and family size. Most of the remaining FHP members will be eligible for a Qualified Health Plan, which is commercial coverage offered through *New York State of Health*. They will also be eligible to receive federal and state subsidies that will cover the costs of their premiums, as well as additional federal subsidies that will help with their cost-sharing responsibilities. The state subsidies will be available to these members as long as they sign up for a silver level plan. For additional details on *Healthfirst Leaf Plans,* see page 4.

Should any Healthfirst members have questions concerning their membership, please refer them to our Member Service number, **1.866.463.6743** or to our website, **www.myhfny.org**.

Key Healthfirst Contacts

Member Services
1.866.463.6743
Monday-Friday, 8am to 6pm
TTD/TTY: (Hearing & Speech Impaired)
English: 1.888.542.3821
Spanish: 1.888.867.4132

Provider Services
1.888.801.1660
Monday-Friday, 9am to 5pm
hfprovsrvs@healthfirst.org

TIMELINE

October 1, 2013–March 31, 2014
- Open Enrollment Period

December 31, 2013
- Last day for new member enrollment into Family Health Plus Program
- Family Health Plus members who are Medicaid-eligible will need to re-enroll into Medicaid through Healthfirst
- Family Health Plus members who are not Medicaid-eligible will be qualified for the Healthfirst Silver Leaf Plan

January 1, 2014
- New enrollees for Medicaid will need to go through the *New York State of Health*

April 1, 2014
- Family Health Plus members who have their renewal date after March 31, 2014 will need to re-enroll in new coverage (Medicaid or Healthfirst Silver Leaf Plan) through the *New York State of Health*

October 1, 2014
- Child Health Plus and Medicaid renewals will be processed through the *New York State of Health*

December 31, 2014
- The Family Health Plus product will end but all FHP members have the opportunity to re-enroll in our Medicaid product or Healthfirst Silver Leaf Plan based on eligibility

Medicaid Primary Care Rate Increase (PCRI)

The Affordable Care Act, signed into law in 2010, requires that Medicaid payments be consistent with efficiency, economy, and quality of care, and that a minimum amount is reimbursed for certain primary care services delivered by designated primary care physicians. The specific primary care services defined in the Act include certain procedure codes for evaluation and management (E&M) services and certain vaccine administration codes. Under this provision, effective January 1, 2013, managed care organizations are required to reimburse eligible Medicaid PCPs at least as much as the Medicare physician fee schedule (MPFS) rate in CYs 2013 and 2014. The directive for payment at the Medicare rate extends to primary care services paid on a fee-for-service (FFS) basis, as well as to those paid on a capitated or other basis by Medicaid Managed Care plans. In New York State, all providers who qualify for the increased payment amount in CYs 2013 and 2014 are maintained on a list at **www.health.ny.gov/health_care/medicaid/fees**.

As you are already aware, New York State and all Medicaid Managed Care plans throughout the state have been working together to develop and implement the methodology to pay eligible providers retroactive to January 1, 2013, and then process payments going forward until the expiration of the provision. All plans are required to submit payment reports to New York State by October 25, 2013, and to issue payments to providers, in accordance with the State schedule, by January 31, 2014.

Healthfirst is currently in the process of identifying the claims eligible for the Medicaid Primary Care Rate Increase (PCRI) based on the New York State provider list and eligible procedure codes. Our reimbursement methodology is outlined below.

Fee-for-Service Payments

- Healthfirst will identify all procedure codes submitted by eligible providers from dates of service rendered on January 1, 2013 through June 30, 2013
- The Healthfirst contractual amount paid to the eligible provider will be compared to the greater of the 2013 Medicare Physician Fee Schedule or the 2009 Medicare CF
- The positive difference resulting from the above calculation will be the amount due to the provider. Any negative values will be set to zero and will have no impact on the final total
- Reports will be submitted to New York State by October 25, 2013, and payments will be issued to providers, in accordance with the State schedule, by January 31, 2014

Capitated Payments

- Similar to FFS payments, Healthfirst will identify all procedure codes submitted by eligible providers from dates of service rendered on January 1, 2013 through June 30, 2013
- Healthfirst will allocate a portion of primary care capitation to each eligible procedure code
- The portion of primary care capitation allocated to each eligible procedure code will be compared to the greater of the 2013 Medicare Physician Fee Schedule or the 2009 Medicare CF
- The positive difference resulting from the above calculation will be the amount due to the provider. Any negative values will be set to zero and will have no impact on the enhanced payment
- Reports will be submitted to New York State by October 25, 2013, and payments will be issued to providers, in accordance with the State schedule, by January 31, 2014

If you have any questions about the Healthfirst payment methodology or our timeframe for implementation, please contact the Provider Services hotline at **1.888.801.1660** (Monday–Friday, 9am–5pm).

Preparing for ICD-10

On **October 1, 2014**, the healthcare industry will transition from ICD-9 to ICD-10 codes for diagnoses and inpatient procedures. Please note that the change to ICD-10 does not affect CPT coding for outpatient procedures and physician services.

Understanding the Basics

The Centers for Medicare & Medicaid Services (CMS) has compiled several fact sheets that will introduce you to ICD-10, explain why it's necessary, and give you the information you'll need to get started on your transition.

- **ICD-10 FAQs**
  www.cms.gov/medicare/coding/icd10/downloads/icd10faqs2013.pdf
- **The ICD-10 Transition: An Introduction**
  www.cms.gov/medicare/coding/icd10/downloads/icd10_introduction_060413[1].pdf
- **ICD-10 Basics for Medical Practices**
  www.cms.gov/medicare/coding/icd10/downloads/icd10_basics_for_medical_practices_060413[1].pdf
- **Talking to Your Vendors About ICD-10: Tips for Medical Practices**
  www.cms.gov/medicare/coding/icd10/downloads/icdtalkingtoyourvendorsformedicalpractices[1][1].pdf
- **ICD-10 and CMS eHealth: What's the Connection?**
  www.cms.gov/medicare/coding/icd10/downloads/icd-10andcmsehealth-whatstheconnection_071813remediated[1].pdf
- **ICD-10 Basics for Small and Rural Practices**
  www.cms.gov/medicare/coding/icd10/downloads/icd10basicssmallandruralpractices[1].pdf

Implementation guides, timelines, and checklists

CMS has also provided checklists and timelines that give an at-a-glance view of what you need to do to get ICD-10-ready. The ICD-10 implementation guides provide detailed information about the ICD-10 transition. CMS has also developed an online ICD-10 implementation guide, which is a web-based tool that provides step-by-step guidance on how to transition to ICD-10 for small/medium practices, large practices, small hospitals, and payers. Please note that the dates and milestones in these materials are recommendations only; you can adapt them to your needs for meeting the **October 1, 2014** deadline.

Online ICD-10 Implementation Guide

- **Online ICD-10 Guide**
  implementicd10.noblis.org

Checklists with ICD-10 transition tasks and estimated timeframes

- **Large Practices**
  www.cms.gov/medicare/coding/icd10/downloads/icd10largepracticeschecklisttimeline.pdf
- **Small and Medium Practices**
  www.cms.gov/medicare/coding/icd10/downloads/icd10smallmediumchecklisttimeline.pdf
- **Small Hospitals**
  www.cms.gov/medicare/coding/icd10/downloads/icd10smallhospitalschecklisttimeline.pdf

Timelines with suggested dates for important ICD-10 transition activities

- **Large Practices**
  www.cms.gov/medicare/coding/icd10/downloads/icd10largepracticeschecklisttimeline.pdf
- **Small and Medium Practices**
  www.cms.gov/medicare/coding/icd10/downloads/icd10smallmediumtimelinechart.pdf
- **Small Hospitals**
  www.cms.gov/medicare/coding/icd10/downloads/icd10smallhospitalstimelinechart.pdf

Implementation Guides

- **Large Practices**
  www.cms.gov/medicare/coding/icd10/downloads/icd10_largepractice_handbook_060413[1].pdf

- **Small and Medium Practices**
  www.cms.gov/medicare/coding/icd10/downloads/icd-10_small-medpractice_handbook_060413[1].pdf
- **Small Hospitals**
  www.cms.gov/medicare/coding/icd10/downloads/icd10_sm-hosp_handbook_060413[1].pdf

Healthfirst's Approach to ICD-10

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

Large-scale internal testing of ICD-10 started in the last quarter of 2013. Targeted external testing will follow in the first quarter of 2014. Testing will continue through 2014. 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, 2014 ICD-10 compliance date?

Although **October 1, 2014** 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 defining 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 help us fine-tune 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, 2014**, 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, 2014**.

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, 2014**. We will continue to closely follow the communications from the regulatory authority and will adapt our approach as permitted.

Where can I find more information on ICD-10?

These industry resources will help with your planning and preparation:

- **Centers for Medicare & Medicaid Services (CMS)**
  www.cms.gov/icd10
- **Workgroup for Electronic Data Interchange (WEDI)**
  www.wedi.org

Solutions to common medication adherence barriers with diabetics

- Medication nonadherence is prevalent among patients with diabetes mellitus and is associated with adverse clinical outcomes[1].
- Nonadherent diabetes and heart disease patients have significantly higher mortality rates (12.1%) than similar patients who were adherent (6.7%)[2].
- Diabetes patients with poor medication adherence have a 30% yearly risk of hospitalization, as opposed to a 13% risk for those who accurately follow prescriber guidelines[3].
- Total annual healthcare spending for a diabetic patient with low medication adherence ($16,499) is almost twice the amount for a patient with high adherence ($8,886)[4].

Medication adherence is essential to effective diabetes management, and it is vital in keeping our members well. Below is a list of common barriers to medication adherence, along with suggested solutions, as detailed in the NYC DOHMH *City Health Information* "Improving Medication Adherence" (Kansagra et al., 2009).

Healthfirst encourages you to reference this grid and utilize a collaborative team approach when addressing your patients' concerns with their diabetic medications.

Barrier	Suggested Solution
My medicine makes me feel sick	• Explain side effects that are common and tell the patient how to handle them (e.g., call you or the pharmacist). If applicable, let the patient know that the medication may make a person feel worse at first, but that the side effect is expected to go away over time. • If possible, replace with another medication with a different side-effect profile. • For medications in which side effects persist, suggest ways to manage them, such as taking with food (for nausea) or before bed (for dizziness), or staying well hydrated and eating a fiber-rich diet (for constipation). • Discuss the long-term benefits of taking medicine.
I feel fine	• Explain to the patient that, unlike antibiotics, many chronic-disease medications don't make you feel different, even when they are working. The benefits of taking the medication(s) are seen long term. • Reinforce that the medication will help prevent future illness or medical complications. • Remind the patient that many silent diseases like high blood pressure or diabetes can put patients at risk for heart attack or stroke.
I forget	• Instead of a 30-day prescription, write a 90-day prescription; suggest reminders such as a pill box or cell phone alarm. • Fill out a medication list with the patient. • Suggest that the patient pick a pharmacy that uses a refill reminder system.
My medicine costs too much	• Switch the patient to an equally effective generic or less expensive medication, if possible. • Be sure that the patient is not taking unnecessary medications. • Provide prescription assistance program resources.
It's too complicated	• Determine whether any medications the patient is on can be safely discontinued. • Prescribe a long-acting formulation, if appropriate. • Determine whether the patient can take a combination pill that is affordable. • Review patient medication reminder tools.

For more information on medication adherence resources and tools, please visit Healthfirst's website at **www.healthfirst.org**.

[1] P. Michael Ho, MD, PhD; John S. Rumsfeld, MD, PhD; Frederick A. Masoudi, MD, MSPH; David L. McClure, PhD, MSc; Mary E. Plomondon, PhD, MSPH; John F. Steiner, MD, MPH; David J. Magid, MD, MPH. *Effect of Medication Nonadherence on Hospitalization and Mortality Among Patients With Diabetes Mellitus.* Arch Intern Med., 2006. Vol 166: 1836–1841.

[2] Osterberg L., Blashchke T. *Adherence to medication.* N Engl J Med., 2005; 353(5): 487–497.

[3] Sokol M.C., McGuigan K.A., Verbrugge R.R., Epstein R.S. *Impact of medication adherence on hospitalization risk and healthcare cost.* Med Care., 2005; 45(6): 521–530.

[4] Ho, P.M., Magid, D.J., Masoudi, F.A., et al. (2006). *Adherence to cardioprotective medications and mortality among patients with diabetes and ischemic heart disease.* BMC Cardiovasc. Disord.: 6, 48.

Vital Signs: Preventable deaths from heart disease & stroke

More than 200,000 preventable deaths from heart disease and stroke occurred in the United States in 2010, according to a new *Vital Signs* report from the Centers for Disease Control and Prevention (CDC). More than half of those who died were under 65. Blacks are nearly twice as likely as whites to die from preventable heart disease and stroke.

CDC Director Tom Frieden, MD, MPH, says cardiovascular diseases, including heart disease and stroke, kill nearly 800,000 Americans each year, a figure that represents nearly 1 in every 3 deaths. "Despite progress against heart disease and stroke, hundreds of thousands of Americans die each year from these preventable causes of death. Many of the heart attacks and strokes that will kill people in the coming year could be prevented by reducing blood pressure and cholesterol and stopping smoking," he said.

The *Vital Signs* report looked at preventable deaths from heart disease and stroke (defined as those that occurred in people under age 75) that could have been prevented by more effective public health measures, lifestyle changes, or medical care. While the number of preventable deaths has declined in people aged 65 to 74 years, it has remained unchanged in people under age 65. Men are more than twice as likely as women to die from preventable heart disease and stroke; and across all races and ethnic groups, black men are most at risk.

To learn more about heart disease and stroke prevention, visit CDC's Division for Heart Disease and Stroke Prevention at **www.cdc.gov/dhdsp**. More information on *Vital Signs*, a report that provides the latest data and information on key health indicators, is available at **www.cdc.gov/VitalSigns/HeartDisease-Stroke**.

Source: www.millionhearts.hhs.gov/resources/vital_signs.html#vshd

Healthcare providers are the first line of defense when it comes to diagnosing and treating asthma patients

About one in every 13 people in the United States has asthma, a major cause of illness and disability. Failure to control asthma inflicts a considerable burden on patients, families, and healthcare systems. For healthcare professionals who deliver care to individuals with asthma and their families, unplanned acute-care visits for asthma attacks also disrupt practice schedules, and shift patient care out of primary care settings and into emergency rooms and hospital beds.

Clinical trials show that asthma control is within reach for most individuals who have asthma, yet this chronic inflammatory disorder of the airways remains under-recognized and under-treated. The gap between what the scientific literature shows us works and what we do is evident—less than a third of people with persistent asthma take inhaled corticosteroids to control it.

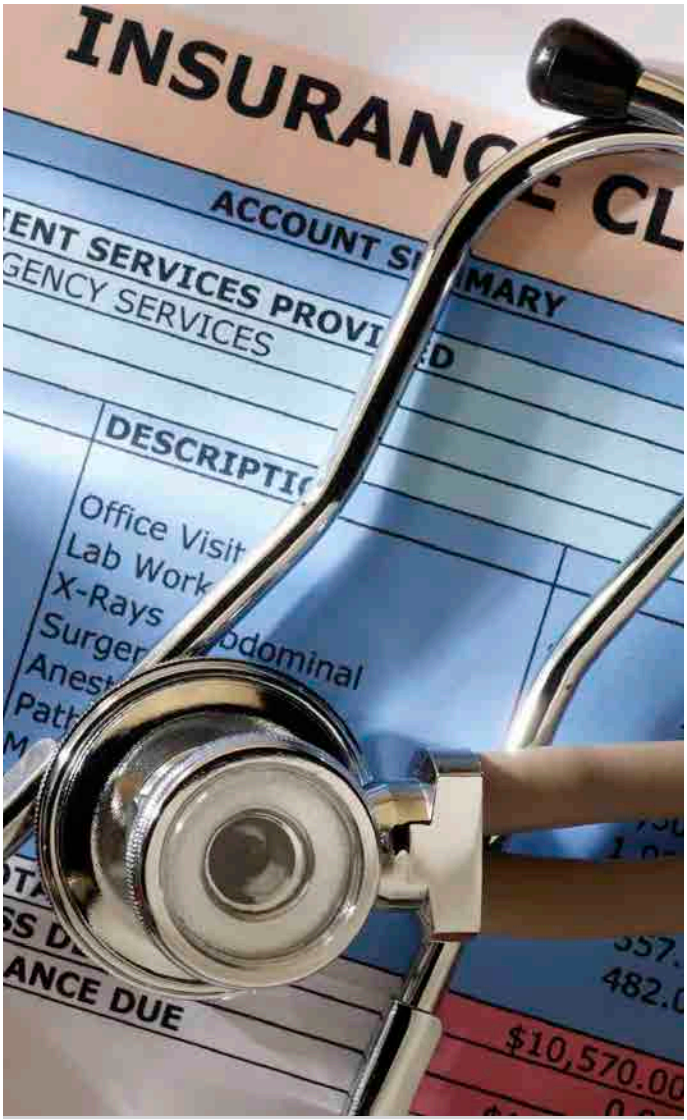
Aim for asthma control

To help close this gap, the National Asthma Education and Prevention Program (NAEPP)'s latest *Guidelines for the Diagnosis and Management of Asthma (EPR-3)* presents a new focus on monitoring asthma control. Asthma control is the degree to which asthma-related symptoms, functional impairment, and risk of untoward events are minimized and the goals of therapy are met. Simply put, the aim of asthma management is to achieve and maintain asthma control so that people with asthma can stay active and sleep well.

To reinforce the essential aspects of effective asthma management, the EPR-3's companion *Guidelines Implementation Panel (GIP) Report: Partners Putting Guidelines into Action* prioritized six clinical practice recommendations that could reduce both the individual and the societal burden of asthma if implemented broadly. You can make a difference now by weaving these six GIP strategies into your own practice.

- Use inhaled corticosteroids to control asthma.
- Use written asthma action plans to guide patient self-management.
- Assess asthma severity at the first visit to determine initial treatment.
- Assess and monitor asthma control at each follow-up visit and adjust treatment if needed.
- Schedule follow-up visits at periodic intervals.
- Control exposure to allergens and irritants that worsen the patient's asthma.

Source: www.nhlbi.nih.gov/health/prof/lung/asthma/naci/audiences/healthcare-professionals.htm



Pre-payment review of professional claims

As of September 2013, Healthfirst began a pre-payment review of professional claims. This pre-payment review will expand to institutional claims by first quarter 2014. Healthfirst is working together with our partner, GDIT (ViPS), Inc., to conduct this review.

As part of the Affordable Care Act of 2010 (ACA), funds were set aside to expand tools for the prevention and detection of fraudulent and wasteful activity. The ACA lays the groundwork to improve anti-fraud and abuse measures by focusing on prevention rather than on the traditional "pay and chase" model after the claim is paid. Claims pre-payment reviews are an integral part of this expansion. Currently, New York is not one of the states that will require pre-payment reviews of claims. However, we expect this requirement to expand to other states, and to include New York, in the near future, based on the Centers for Medicare and Medicaid Services' guidance.

Most providers will likely not experience any noticeable difference in the service and claims processing turnaround time they have come to expect from Healthfirst. However, your office might receive a request from GDIT (ViPS), Inc. for additional documentation if your claim is flagged based on the outcomes of the review. We thank you in advance for your prompt response and for providing us with the requested information so that we can close out the request in a timely manner.

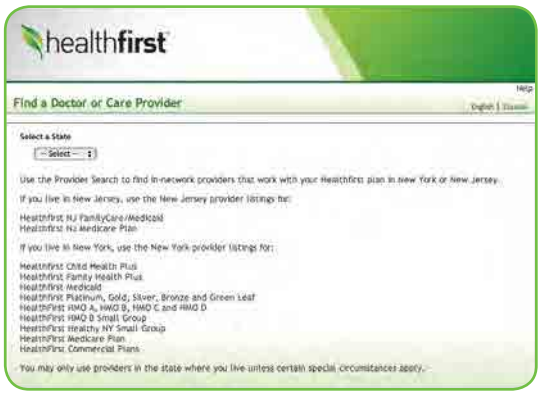
If you have questions about this project, please contact your network representative or our Provider Services team at **1.888.801.1660** (Monday–Friday, 9am–5pm).

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 improvements.



Provider Manual

To review and download the most current Provider Manual, please visit **www.healthfirst.org/provider-manual.html**.

Compliance Corner

Healthfirst's Compliance Program is designed to reduce or eliminate fraud, abuse, and issues of noncompliance; to ensure Healthfirst's compliance with applicable regulations; and to reinforce Healthfirst's commitment to ***zero-tolerance*** for such activities.

Compliance is ever-changing, and the key to keeping up with those changes is communication. We always welcome feedback. You may email Sonya Henderson, Vice President, Compliance and Audit, Compliance Officer, at **compliance@healthfirst.org** with your thoughts, questions, or suggestions.

News & Updates

FDR Attestation Process

Healthfirst' s commitment to compliance includes ensuring that our First Tier, Downstream and Related Entities (FDRs), and Affiliates are in compliance with applicable state and federal regulations. As a network provider of Healthfirst, you fall within this category. Healthfirst has developed a process to validate that each contracted provider meets these requirements.

Healthfirst contracts with FDRs and Affiliates, like yourself, who provide administrative or healthcare services to our members; we are ultimately responsible for fulfilling the terms and conditions in our contract with the Centers for Medicare & Medicaid Services (CMS) and for meeting the Medicare and Medicaid requirements.

A website has been developed to provide you with important information. You can visit **www.healthfirstFDR.org** to review the FDR and Affiliate Compliance Guide, which includes the FDR and Affiliate compliance requirements, and to complete the FDR Compliance Attestation. We are available to answer any questions you may have about the process. You can contact us at **compliance@healthfirst.org** or call **1.212.324.2699**.

The "HEAT" is on...

In 2009, the Department of Health and Human Services (HHS) and the Department of Justice (DOJ) created the Health Care Fraud Prevention and Enforcement Action Team (HEAT) to combat Medicare fraud. Within the past year, efforts by HHS have expanded by creating public-private relationships with major healthcare companies to expand their oversight, enforcement, and investigations. HEAT is working on a daily basis to combat Medicare fraud on both the state and the federal level. For more information about HEAT's activities and recent enforcement actions, you can visit **www.stopmedicarefraud.gov/aboutfraud/heattaskforce/index.html**.

Facts about Exclusions

Healthfirst strives to ensure that all business is conducted in accordance with the law. This includes ensuring that our providers and certain businesses that provide services on our behalf are eligible entities. The Federal HHS Office of Inspector General, as well as State Medicaid Offices, can exclude individuals or entities (e.g., providers, companies, executives) for offenses committed during their course of work: patient abuse, healthcare fraud, or other related crimes. Exclusions can also apply under a multitude of other authorities and reasons: quality of care, loss of licensure, and certain misdemeanor convictions.

Did you know…?

- No payment may be made by any federal or state healthcare program for services (healthcare, administrative, or management) furnished, ordered, prescribed, or provided by an excluded individual or entity? This includes anyone who employs or contracts with an individual or entity that is on an exclusionary list.

- Exclusion from the Medicare and/or Medicaid program can be for any of a number of defined periods—several years or permanently, in some cases—and applies across all states?

Additional information may be found by visiting the OIG HHS webpage at **oig.hhs.gov/compliance/provider-compliance-training/index.asp**.

2014 Healthfirst Medicare Stars Formulary* update

Drugs represented have been reviewed by a National Pharmacy and Therapeutics (P&T) Committee and are approved for inclusion in the Healthfirst formulary.

Frequently Asked Questions:

1. How do I know what medications are covered?
   a. Visit **www.healthfirst.org/providerservices** to view the most up-to-date comprehensive 2014 Medicare Part D formulary.
   b. The chart below includes generic and preferred formulary options. Brand medications are listed in all CAPS; generics are listed in lowercase.
2. How do I go about switching my patient to a formulary alternative?
   a. Refer to the Healthfirst formulary listing for a preferred formulary drug.
   b. Alert the member to a therapy change and get the name of the pharmacy where the member has their prescriptions filled.
   c. Call or fax a member's new prescription to their preferred pharmacy for fulfillment. Written prescriptions (i.e., controlled substance prescriptions) can be given to the patient to fill at their pharmacy of choice within the Healthfirst network.

Therapeutic Class	Formulary Suggestions	Requirements/Limits
Oral Diabetic Medications **High-Risk Medication (HRM). Avoid use in the elderly (> 65 years of age).*	Acarbose	
	Glimepiride 1mg	Quantity Limit (240 tabs/30 days)
	Glimepiride 2mg	Quantity Limit (120 tabs/30 days)
	Glimepiride 4mg	Quantity Limit (60 tabs/30 days)
	Glipizide/Metformin tab 2.5-250mg	Quantity Limit (240 tabs/30 days)
	Glipizide/Metformin tab 2.5-500mg	Quantity Limit (120 tabs/30 days)
	Glipizide/Metformin tab 5-500mg	Quantity Limit (120 tabs/30 days)
	Glipizide tab 5mg	Quantity Limit (240 tabs/30 days)
	Glipizide tabs 10mg	Quantity Limit (120 tabs/30 days)
	Glipizide TB24 2.5mg	Quantity Limit (240 tabs/30 days)
	Glipizide TB24 5mg	Quantity Limit (120 tabs/30 days)
	Glipizide TB24 10mg	Quantity Limit (60 tabs/30 days)
	Glyburide/Metformin tab 1.25-250mg*	***Prior Authorization Required*** Quantity Limit (240 tabs/30 days)
	Glyburide/Metformin tab 2.5-500mg*	***Prior Authorization Required*** Quantity Limit (120 tabs/30 days)
	Glyburide/Metformin tab 5-500mg*	***Prior Authorization Required*** Quantity Limit (120 tabs/30 days)
	Glyburide 1.25mg*	***Prior Authorization Required*** Quantity Limit (480 tabs/30 days)
	Glyburide 2.5mg*	***Prior Authorization Required*** Quantity Limit (240 tabs/30 days)
	Glyburide 5mg*	***Prior Authorization Required*** Quantity Limit (120 tabs/30 days)
	Glyburide micronized 1.5mg*	***Prior Authorization Required*** Quantity Limit (240 tabs/30 days)
	Glyburide micronized 3mg*	***Prior Authorization Required*** Quantity Limit (120 tabs/30 days)
	Glyburide micronized 6mg*	***Prior Authorization Required*** Quantity Limit (60 tabs/30 days)
	JANUMET	Quantity Limit (60 tabs/30 days)
	JANUMET XR TAB 50-500mg	Quantity Limit (60 tabs/30 days)
	JANUMET XR TAB 50-1,000mg	Quantity Limit (60 tabs/30 days)
	JANUMET XR TAB 100-1,000mg	Quantity Limit (30 tabs/30 days)
	JANUVIA	Quantity Limit (30 tabs/30 days)
	JENTADUETO	Quantity Limit (60 tabs/30 days)
	JUVISYNC	Quantity Limit (30 tabs/30 days)
	Metformin hcl TABS 500mg	Quantity Limit (150 tabs/30 days)
	Metformin hcl TABS 850mg	Quantity Limit (90 tabs/30 days)
	Metformin hcl TABS 1,000mg	Quantity Limit (75 tabs/30 days)

* We recognize that there are patient-specific variables which may not be available to us that require use of a product not covered on our 2014 Medicare Part D Formulary. If a nonformulary product is medically necessary, a formulary exception can be requested by calling 1-855-344-0930, faxing 1-855-633-7673, or contacting CVS Caremark Prior Authorization Department, MC 109, P.O. Box 52000, Phoenix, AZ 85072-2000.

Therapeutic Class	Formulary Suggestions	Requirements/Limits
Oral Diabetic Medications *(cont.)*	Metformin hcl TB24 500mg	Quantity Limit (120 tabs/30 days)
Oral Statin Medications	Atorvastatin calcium	Quantity Limit (30 tabs/30 days)
	CRESTOR	Quantity Limit (30 tabs/30 days)
	Lovastatin 10mg	Quantity Limit (30 tabs/30 days)
	Lovastatin 20mg	Quantity Limit (120 tabs/30 days)
	Lovastatin 40mg	Quantity Limit (60 tabs/30 days)
	Pravastatin sodium	Quantity Limit (30 tabs/30 days)
	Simvastatin TABS	Quantity Limit (30 tabs/30 days)
Angiotensin Converting Enzymes (ACE) Inhibitors	Benazepril hcl TABS	
	Captopril TABS	
	Enalapril maleate TABS	
	Fosinopril sodium	
	Lisinopril TABS	
	Moexipril hcl	
	Perindopril erbumine	
	Quinapril hcl	
	Ramipril	
	Trandolapril	
Angiotensin II Receptor Antagonist (ARBS)	BENICAR 5mg	Quantity Limit (60 tabs/30 days)
	BENICAR 20mg	Quantity Limit (30 tabs/30 days)
	BENICAR 40mg	
	DIOVAN 40mg, 80mg, 160mg	Quantity Limit (60 tabs/30 days)
	DIOVAN 320mg	
	Losartan potassium 25mg, 50mg	Quantity Limit (60 tabs/30 days)
	Losartan potassium 100mg	
ARB Combinations	AZOR 10-40mg 2	
	AZOR TAB 5-20mg	Quantity Limit (30 tabs/30 days)
	AZOR TAB 5-40mg	Quantity Limit (30 tabs/30 days)
	AZOR TAB 10-	Quantity Limit (30 tabs/30 days)
	BENICAR HCT 40-25mg	
	BENICAR HCT TAB 20-12.5mg	Quantity Limit (30 tabs/30 days)
	BENICAR HCT TAB 40-12.5mg	Quantity Limit (30 tabs/30 days)
	EXFORGE 10-320mg	
	EXFORGE HCT 5-160-12.5mg	Quantity Limit (30 tabs/30 days)
	EXFORGE HCT 5-160-25mg	Quantity Limit (60 tabs/30 days)
	EXFORGE HCT 10-160-12.5mg	Quantity Limit (30 tabs/30 days)
	EXFORGE HCT 10-160-25mg	Quantity Limit (30 tabs/30 days)
	EXFORGE HCT 10-320-25mg	
	EXFORGE TAB 5-160mg	Quantity Limit (30 tabs/30 days)
	EXFORGE TAB 5-320mg	Quantity Limit (30 tabs/30 days)
	EXFORGE TAB 10-160mg	Quantity Limit (30 tabs/30 days)
	Losartan-hctz 50-12mg	Quantity Limit (30 tabs/30 days)
	Losartan-hctz 100-12.5mg	Quantity Limit (30 tabs/30 days)
	Losartan-hctz 100-25mg	
	TRIBENZOR 40-10-25mg	
	TRIBENZOR TAB 20-5-12.5mg	Quantity Limit (30 tabs/30 days)
	TRIBENZOR TAB 40-5-12.5mg	Quantity Limit (30 tabs/30 days)
	TRIBENZOR TAB 40-5-25mg	Quantity Limit (30 tabs/30 days)
	TRIBENZOR TAB 40-10-12.5mg	Quantity Limit (30 tabs/30 days)
	Valsartan & hctz tab 80-12.5mg	Quantity Limit (30 tabs/30 days)
	Valsartan & hctz tab 160-12.5mg	Quantity Limit (30 tabs/30 days)
	Valsartan & hctz tab 160-25mg	Quantity Limit (30 tabs/30 days)
	Valsartan & hctz tab 320-12.5mg	
	Valsartan-hctz tab 320-25mg	

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

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